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THE MEDICARE HOME CARE BENEFIT: ACCESS AND QUALITY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

LAKEWOOD, NJ

AUGUST 3, 1987

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CONTENTS

Page

Opening statement by Senator Bill Bradley, presiding 1

CHRONOLOGICAL LIST OF WITNESSES

Savage, Evelyn K., R.N., M.A., president, Home Health Agency Assembly of New Jersey, and executive director, Visiting Nurse Association of Somerset Hills, NJ 3
Gross, Joel S., M.D., medical director, Greenwall Geriatric Program, Monmouth Medical Center, Long Branch, NJ 5
Freeman, Pat, legislative chair, Monmouth County Chapter, Older Women's League 9
Abrams, Esther C., chairwoman, New Jersey State Legislative Committee, American Association of Retired Persons 15
Dolan, Kenneth R., executive director, Home Care Council of New Jersey 16
Pearlman, Philip H., president, New Jersey Association of Area Agencies on Aging 21
Dietrich, Theresa, program development specialist, New Jersey Department of Community Affairs, Division on Aging 27
Edelson, Edith, New Jersey Federation of Senior Citizens, Inc 29
Rubenstein, Philip, executive director, Ocean County Office on Aging 31

APPENDIX

Item 1. Testimony from the Ocean County Health Department, submitted by Dale Wilson, R.N., M.S.N., assistant director, Public Health Nursing Services, re: the Medicare Home Health Services Improvement Act of 1987 37
Item 2. Testimony from the New Jersey Council of Senior Citizens, submitted by David Keiserman, legislative representative, re: medical needs of the Nation 39
Item 3. Testimony from the New Jersey Occupational Therapy Association, submitted by Theodosia T. Kelsey, FAOTA, OTR, president, re: redefining the terms intermittent and homebound to include more people and including occupational therapy as a skilled/qualifying service 40
Item 4. Statement of Stella Lass, acting president, North Broward Homebound Program, Pompano Beach, FL, re: long-term care for the homebound not eligible for Medicaid 42
Item 5. Testimony from the Discharge Planning Nurse Coordinators of New Jersey, submitted by Sharon Breidt, R.N., staff nurse, extended intake coordinator, Middlesex County Visiting Nurses Association, re: the definition of the term homebound/bedbound and the need for occupational therapy 44

THE MEDICARE HOME CARE BENEFIT: ACCESS AND QUALITY

MONDAY, AUGUST 3, 1987

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Lakewood, NJ.

The committee met, pursuant to notice, at 9 a.m., at the Elinore Levovitz Apartments, Lakewood, NJ, Hon. Bill Bradley presiding.

Present: Senator Bradley.

Staff present: Ray Bramucci, New Jersey State Director for Bill Bradley; Ken Apfel, Consultant, Senate Aging Committee; Rose Brunetto, Staff Assistant, Senator Bradley; Jim Pennestri, Staff Assistant, Senator Bradley; and Rima Cohen, Staff Assistant, Senator Bradley.

OPENING STATEMENT BY SENATOR BILL BRADLEY

Senator BRADLEY. Let me convene this hearing officially.

As you see, my gavel's a little different today than usual.

This is the hearing of the Special Committee on Aging of the U.S. Senate. I have convened this hearing today to review the state of home health care services.

Thank you very much, Rabbi, for your introduction and involvement. I appreciate that very much.

Let me also say how much I appreciate the welcome by Freeholder Director Buckwald for stopping by today to welcome us to Ocean County. You were very kind to do that, and I appreciate that. It shows your great sensitivity to the subject of this hearing and the needs of the elderly in Ocean County.

I understand that we had Mayor Richard Work who was to come by and offer his welcome, and because he is not here at the moment, we will have to begin the hearing.

I have convened this hearing today to review the state of home health care services for the elderly in New Jersey. It comes approximately a year after a Senate Committee on Aging hearing that I held in Newark. Last year's hearing solicited testimony from Medicare recipients and health care providers in response to complaints that Medicare has systematically denied home health benefits authorized under the law.

The reports heard at that hearing, needless to say, were disturbing. I learned that the federal agency that administers the home care benefit, the Health Care Financing Administration [HCFA], through a variety of administrative rulings and red tape, was indeed systematically squeezing down on the level of home care services reimbursed through Medicare. Their policies have caused untold suffering for scores of elderly who have to struggle to find other sources of support once their Medicare coverage ends. And

when there is no family, no friends, and no other caregivers to turn to for assistance, the needs of the elderly go unmet. The only other alternative left to elderly citizens who fall through the cracks is to spend all of their savings and become wards of the state in order to receive the care that they need.

That hearing also revealed that HCFA's policies were inconsistent and arbitrary, making it difficult for beneficiaries and providers to anticipate what services Medicare would reimburse them for. I heard story after story from elderly New Jerseyans, many of whom are caring for even older patients, siblings, or spouses, about their frustrations with vague rules about when home care is authorized.

At the hearing, health care providers also reported stories of vastly different decisions from HCFA on basically similar cases. At the very time Medicare has forced seniors out of hospitals "quicker and sicker," because of the incentives of the new DRG reimbursement method, elderly patients are being denied the necessary continuing support services in the community.

It was obvious to me that legislation was badly needed to remedy these problems. In response, I introduced the Medicare Home Health Services Improvement Act of 1987, a bill designed to clarify, expand, and improve the quality of Medicare's home care benefit. It does so in two ways. First, the bill defines and expands the Medicare home care benefit so HCFA will no longer be able to arbitrarily deny home care services. Second, the bill promotes the health and safety of those receiving home health services by upgrading home health quality standards and accountability.

A detailed summary of my bill will be included in the hearing record at the conclusion of my opening statement.

I am pleased that pieces of this bill are already moving through Congress. The Senate version of the Medicare catastrophic coverage bill, which has already been approved by the Senate Finance Committee, expands Medicare coverage for daily home care from two to three weeks to 45 days and it clarifies the definition of homebound to ensure that homebound is not redefined as bedbound. In addition, I will be doing my best to ensure that the remaining pieces of my home care bill, including the provisions that upgrade quality, streamline the appeals process, and subject HCFA policies to public notice and comment, get included in the September Budget Reconciliation bill.

During this hearing, I hope to get feedback on the changes that have been proposed from New Jersey's aging and health care communities. I hope that witnesses today will offer comments on whether the legislation adequately assures that the elderly will get the quality home care that Congress intended and that they clearly deserve. And, perhaps even more important, I would like to get your ideas of where to go in the future to meet these needs.

Our first panel consists of Evelyn Savage, the President of the Home Health Agency Assembly of New Jersey, who has played a very important roll in structuring the bill that I introduced in 1987.

Our second witness is Joel Gross, who is a doctor and the Director of Greenwall Geriatric Program, Monmouth Medical Center;

and Pat Freeman, Legislative Chairperson of Monmouth County Older Women's League.

So, let me welcome all three of you to the panel. Let me assure you that your full statements will be included in the record; and let me urge you to summarize your testimony in not more than five minutes, so that we have a chance to hear from all of the witnesses and still conclude in a timely manner.

Welcome to the Committee. Ms. Savage, maybe you'd like to go first.

STATEMENT OF EVELYN K. SAVAGE, R.N., M.A., PRESIDENT, HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY AND EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION OF SOMERSET HILLS, NJ

Ms. SAVAGE. Thank you, Senator Bradley.

Senator Bradley and other friends, I am Evelyn Savage, President of the Home Health Agency Assembly of New Jersey, speaking on behalf of the Assembly. I am also the director of the Visiting Nurse Association of Somerset Hills in Bernardsville. You may have noticed that I used the word "friends" in addressing you. We are here today to comment on the Senator's Medicare Home Care Improvement Act of 1987. From my perspective, both as president of a statewide association, and from my own experience in Bernardsville I view this legislation as the support, the help, that a good friend reaches out to give when someone is in trouble.

New Jersey home health care providers have been in trouble; and worse, the result of this trouble is that patients are not receiving the care they need. Briefly, in the last few years, the Health Care Financing Administration has unilaterally, without consulting Congress, and without public input, re-interpreted the Medicare home health care benefit to restrict utilization of this benefit. The result in New Jersey has been dramatic.

Since 1983, admissions have declined by approximately 1,000 persons per year and between 1984 and 1985, the total number of visits provided to home health patients declined by over 100,000. And this has happened at a time when our elderly population is increasing and our hospitals are discharging patients promptly to their homes "sicker and quicker."

It is one thing to quote numbers; but let me describe to you the situation of an Ocean County resident which took place just a few months ago. The individual is an elderly man who had been hospitalized for a caudal block for control of spinal stenosis, which is a compressed nerve. The block was unsuccessful and he was in a lot of back pain and this limited his mobility. His condition was also complicated by previous by-pass surgery, an enlarged spleen, severe arthritis, and inoperable prostate problems. The patient has a Foley catheter because of a problem with urine retention.

At the time of admission to home health, in addition to the back pain, swollen feet, and general weakness, the patient was suffering from intermittent diarrhea, dehydration, and had an irregular heart beat. He could not walk, even with a walker, for more than five feet without becoming short of breath and weak. He could not

dress or clean himself. Sadly, his wife was also in a debilitated state and had difficulty caring for herself and her husband.

Under physician instructions, the home health agency sent a nurse to the home for an hour's visit, three times a week, for one month to supervise medications which were changed several times. The nurse also monitored bowel and urine condition; taught the patient and his wife how to care for his catheter; and monitored his heart and lung sounds. A home health aide also made two hour visits three times a week for a month. The aide assisted the patient in eating, dressing, personal hygiene and reinforced physical therapy exercises. Even though it was necessary for the nurse to teach the patient and his wife how to care for the Foley catheter and even though the patient's condition was changing when the nurse visited so that she had to notify the physician who then changed the medication, these visits were denied as "unreasonable and unnecessary."

S-1076 has a number of provisions. Let me comment on how these provisions would specifically turn around the restrictions to care such as experienced by the Ocean County individual.

We commend most heartily the provisions which clarify the ambiguities in eligibility criteria—the definiton of "intermittent care"—which assures that patients needing care can receive daily care of one or more visits, seven days a week, for up to 60 days and the definition of "homebound" to mean having restricted ability to leave home without assistance and not "bedbound" as it has been applied.

We are glad to see Section 3 of this bill, which is the new benefit for post-hospital in-home care, which responds to the need for coverage for patients discharged promptly because of the prospective payment incentives. Under HCFA's current restrictive interpretations, it is difficult to assure that these patients receive adequate and appropriate care.

We are also pleased to show that S-1076 addresses the problem of delays in reconsiderations of appeals for denials. Appealing claims, even when successful, is a very time consuming and costly process. We prefer to give our energies to caring for patients. But, we are the advocates of our patients, and we believe that when we give care to patients who are entitled to care under the Medicare law, then we must pursue the reimbursement for that care. All home health agencies suffer cash flow problems while waiting for disputed cases to be resolved. At present, there is no incentive for the fiscal intermediary to promptly resolve disputes. This bill would add a measure of fairness by requiring that the intermediary has an incentive to respond in a timely fashion.

We commend Senator Bradley for addressing the issues of quality care for home care consumers. In Federal-State responsibilities in assuring quality care. In this regard, we recognize that the states will need additional federal funding support if they are to carry out their oversight mandate.

Finally, we approve a number of other points, such as the inclusion of occupational therapy as a qualifying service for home care; requiring HCFA to publish rule changes, the rural/urban cost study, and updating wage index information.

Senator Bradley, we are impressed by your understanding of the complexities of the health care system and moved by your compassion for the needs of elderly persons. On behalf of the home health agencies in New Jersey and the patients we serve, I thank you.

Senator BRADLEY. Thank you very much, Ms. Savage.

Our next witness is Dr. Gross, Dr. Joel Gross, Director of Greenwall Geriatric Program, Monmouth Medical Center.

Dr. Gross, welcome.

STATEMENT OF JOEL S. GROSS, M.D., MEDICAL DIRECTOR, GREENWALL GERIATRIC PROGRAM, MONMOUTH MEDICAL CENTER, LONG BRANCH, NJ

Dr. GROSS. Thank you, Senator.

Senator Bradley, it's a privilege, indeed, and I welcome the opportunity to appear before this Senate Special Committee on Aging to discuss the issues of the Senate Bill 1076, a bill to amend Title XVIII of the Social Security Act to improve the availability of home health services under the Medicare Program.

For 22 years Medicare has attempted to improve the health and well-being of our nation's senior citizens and unfortunately the plight of our older adults remains characterized by insufficient health care for the patient in his most suitable and familiar surroundings, his home.

Medicare is structured for the acutely ill patient in a hospital setting and the elderly have been woefully neglected in terms of satisfactory home health care. This bill proposes to bridge the apparently ever widening gap between needed home care services and the willingness of the Federal Government to pay for these basic necessities.

Being a geriatrician gives me the insight and first-hand experience to deal with the very special needs of our older adults. All my patients are senior citizens, and I feel one of the most serious health care problems facing my patients is the potential and realized loss of the most precious and unalienable rights, the right to strive and to be entitled to independence. This independence that I speak of is a functional independence; their independence and ability to transfer out of a bed, to perform personal hygiene, to bathe and toilet themselves without becoming a burden to others. Your bill appears to improve the plight of the senior citizens, and I welcome this bill.

As you had said, Senator, patients in 1987 are becoming discharged sooner, and as said before, quicker and sicker. And this individual will face new challenges at home, unless improved home health care services are provided.

Currently, HCFA intermediaries who are charged with evaluating claims from the home health care agencies are not often, if at all, trained in understanding geriatric and gerontology and the special needs of our older adults. Their needs are very complex and multi-dimensional, and a key understanding of their special needs is essential for optimum delivery of home health care.

Perhaps, increased education and the training of HCFA intermediaries in geriatrics and gerontology may result in improvement of

home health care services and improvement into the guidelines for appropriate home health care delivery.

Looking at a recent example, there was an individual that suffered a fracture of the lower extremity. This individual had other multiple—as commonly seen—medical problems. This individual was not able to complete an adequate course of rehabilitation in the hospital. Home health care services were offered and delivered through physical therapy.

The patient, over several weeks, improved significantly; however, the home health care agency was denied payment stating that the home health care service should not have been offered and that the hospital should have performed the services. But as mentioned before, because of regulations, the patient was discharged home, likely prematurely.

Looking at another example, a similar fractured lower extremity of an individual, an older adult, had a cast placed on in the emergency room. There was insufficient time for this patient to be taught how to safely transfer out of the bed to a chair, or out of a bed to a walker.

This teaching is essential for the individual to decrease his or her risk of a hip fracture, head trauma, and becoming further bedridden.

Again, physical therapy was offered at home, and the home health care agency was denied payment on the basis that in the emergency room this type of therapy should have been provided.

As mentioned before, these HCFA intermediaries need to have more of a training and understanding into the very unique and multi-dimensional needs of our older adults.

Also, a recent case of an individual who was being treated with chemotherapy in the doctor's office on a weekly basis needed to be physically transported by the relatives to the doctor's office, as chemotherapy being administered at home may at times become very dangerous, unless a physician is there to help supervise and monitor for serious side effects. This individual had also a denial of home health care benefits, stating that if the individual could make it to the doctor's office, therefore, he is not considered homebound, and all home health care services would be denied.

Senator Bradley's bill would define, as mentioned before, "homebound", any person that has a condition that restricts his or her act to leave the home without support or to those situations where leaving the home is medically contra-indicated.

This I applaud greatly. The length of time that an elderly individual needs to heal is known to be significantly increased compared to those of younger individuals. Unfortunately, HCFA intermediaries appear to know little of the healing process and the length of time that's necessary for satisfactory recuperation.

Senator Bradley's bill would modify the statute for patients to receive home care services under Medicare on a daily basis for a period of 60 days or longer when the patient's physician certifies that exceptional circumstances require continued daily services.

I must add that here continuity between the acute care setting and the home care setting is a critical factor which is often neglected. Similar treatment plans, especially in the area of rehabilitation therapy, is of extreme importance. Early continuation of treatment

may often be the key to prevent re-hospitalization and premature institutionalization. Upgrading HCFA by including quality insurance provisions can only serve to improve the delivery of optimal geriatric home health care.

So, in summary, Senator Bradley, I wish to applaud your efforts to significantly revise and upgrade the eligibility requirements for our elderly patients to receive needed home health care services. The prejorative phrase of "no care is better then home care" can hopefully be totally erased from the minds of our senior citizens who are not only in the most need for, but in this geriatrician's view, deserve the best care our country can offer.

Let us not forget that a nation can and should be judged on the manner in which it cares for its elderly.

Thank you.

[The prepared statement of Dr. Gross follows:]

PREPARED STATEMENT OF JOEL S. GROSS, M.D.

Thank you, Senator Bradley. Senator Bradley, I welcome the opportunity to appear before this Senate Special Committee on Aging to discuss the issues of the Senate bill S. 1076, a bill to amend title XVIII of the Social Security Act to improve the availability of home health services under the Medicare Program.

For 22 years Medicare has attempted to improve the health and well-being of our nation's senior citizens and unfortunately the plight of our older adults remains characterized by insufficient health care for the patient in his most suitable and familiar surrounding, i.e., the home. Medicare is structured for the acutely ill patient in a hospital setting and the elderly have been woefully neglected in terms of satisfactory home health care. This bill proposes to bridge the apparently ever widening gap between needed home care services and the ability of the federal government to pay for these basic necessities.

As one of the new fellowship trained geriatricians in the state of New Jersey I am keenly aware of the health care needs of our older adults. One of the most serious health care problems facing my patients is the potential and realized loss of the most precious and unalienable right, the right to strive and be entitled to independence. This independence that I speak about concerns the functional independence of the elderly patient. One of the greatest losses a senior citizens can suffer is not only the loss of a limb or even a loved one but the loss of their ability to live independently and not become a burden to friends or relatives.

When a patient is discharged from a hospital in 1987, that person faces new challenges that pose serious risks to either regain or maintain a level of functional independence. With the advent of diagnosis related groups (DRG) elderly patients are now being discharged in larger numbers and often at earlier times in their illnesses without adequate time for rehabilitation. This translates into more referrals to home health care agencies. Are these agencies able to handle these ever-increasing number of clients?

Under current Medicare guidelines the home health care agencies are facing increasing numbers of denials. A recent survey of New Jersey home health care agencies showed that denials in 1986 increased 255 percent over the past 3 years with over 440 claims being denied in 1986. One agency reported an increase in denials of 75 percent in the first 6 months of 1986 as compared to the entire year of 1985.

It appears to be paradoxical that at a time when our elderly patients are being discharged from a hospital earlier in their hospital course, the home health care agencies are being denied payment for providing needed services to help restore these patients to a reasonable state of function.

Our own Geriatric Program at Monmouth Medical Center recognized the needs of a particular group of frail elderly and worked for some time to secure the funds to provide services. We often refer to "another level of care" which is of vital importance in the continuum of care. Our Community Outreach Teams provide a significant "safety net" for those elderly who are either discharged from home care services, or for those who do not qualify for service. Each of our Teams (and there are two) consists of a Registered Nurse and a Social Worker. They act as educators, case managers and support for the client and caregiver.

A study of our COP Teams completed last summer by a Post-Doctural Fellow in Gerontology found that a large percentage of the clients we serve (37%) were in

need of varying degrees of mental health services. However, these elderly would not qualify for any current community services due to the fact that they were functionally independent. My purpose for mentioning this aspect is to point out that community based service delivery is currently a complex and fragmented system which tends to deny access and accessibility to those most in need.

The HCFA intermediaries who are charged with evaluating claims from the home health care agencies are not often, if at all trained in geriatrics and therefore can understand very little of the complex needs and services that must be supplied to the elderly patient in their home in order to remain functional to any significant degree.

Let us look at a recent example that involved an elderly individual who fractured their lower extremity and required skilled care to teach this patient how to safely transfer from a bed to chair and vice versa. Performing this basic activity of daily living, a seemingly effortless chore for the average adult, if done improperly could result in refracture, head trauma and fear to even leave the confines of the bed which could lead to a spiraling downhill course characterized by decubitus ulcers (bed sores), malnutrition, and pneumonia. Denial to the home health care agency occurred because this form of therapy should have been provided in the hospital. This patient had been unable to receive the necessary therapy due to other complicating medical factors and was discharged before successful completion of therapy. Another individual who had suffered a similar fracture required a long leg cast and also needed instruction in transferring from a bed to chair. This cast was placed in the emergency room and obviously the patient could not have been successfully instructed in proper techniques to accomplish the needed transfers in the emergency room. This was taught by the therapist via the home health care agency. The claim was denied. What would have happened to this patient if the home health care agency fearing that Medicare would have retroactively denied payment, decided not to take on this case?

HCFA intermediaries must have more understanding and training into the very unique and multidimensional needs of our older patients. The bill requiring HCFA intermediaries to promulgate better standards and a timetable for appeals, including a requirement that providers receive an explanation for denials, penalties being charged if reconsiderations are not conducted within sixty days, and intermediary performance on appeals be made part of HCFA's overall appraisal of the intermediary are all welcome amendments to current HCFA intermediary practices.

Elderly patients who are considered homebound are considered eligible to receive Medicare home care coverage. The Medicare manual published 22 years ago explained that for an individual to receive such home care, the patient could be able to leave the home for limited times if these activities were essential in nature. The person did not have to be housebound to qualify for home health care benefits. Twenty-two years later home health care agencies receive denials because HCFA intermediaries have determined that if a patient could leave the house for any reason, he should have been able to find some way to get to the physician's office and not need the services of a home health care agency. A recent denial for a patient who left the home only to receive weekly chemotherapy in the physician's office, shows that the original intent of Medicare's homebound definition was being grossly misinterpreted. With a family at times literally carrying a patient to a car and into a doctor's office, HCFA often states that the individual, if able to visit a physician's office, is not considered homebound and all home health care services can be denied.

Senator Bradley's bill would define as homebound any person that has a condition that restricts his ability to leave the home without support, or to those situations where leaving the home is medically contraindicated. This would be a great benefit to the patient and a boost to the home health care agencies ability to be compensated for services either rendered or to be rendered.

The length of time an elderly patient needs to heal is known to be longer than of a younger individual. When one looks at the current Medicare regulations to be eligible for Medicare home health care benefits the patient must need skilled nursing care on an intermittent basis and recent HCFA instructions appear to restrict this care to patients who need it for only two to three weeks. Most patients who have bed sores require more than twenty one days to heal these lesions. Patients who have fractured their hips often require one to two months and even longer to recuperate to an acceptable level of functioning. A recent example of this inadequate system of eligibility requirement concerned an elderly diabetic man who had undergone amputation of two toes. The attending physician authorized the home health care agency to supply nursing services to attempt to save the rest of the foot and avoid complete amputation of the leg. After five months of intensive nursing service, the foot healed well and the limb was salvaged and further amputation was no

longer necessary. The result was an extremely grateful patient who could walk with minimal assistance but a denial of payment on the premise that claimed the home health care agency should have known it would have taken five months to heal and the need for such nursing services did not have to be provided.

Senator Bradley's bill would modify the statute to permit patients to receive home care services under Medicare on a daily basis for a period of sixty days and longer when the patient's physician certifies that exceptional circumstances require continued daily services. I must add here that continuity between the acute care setting and the home care setting is a critical factor which is often neglected. Similar treatment plans, especially in the area of rehabilitation therapies is of extreme importance. Early continuation of treatment may often be the key to the prevention of rehospitalization or institutionalization.

In summary, I wish to applaud the efforts of Senator Bradley and his attempt to significantly revise and upgrade the eligibility requirements for our elderly patients to receive needed home health care services. The perjorative phrase of "no care is better than home care" can hopefully be totally erased from the minds of our senior citizens who not only are in the most need for, but in this geriatrician's view, deserve the best care our country can offer.

Let us not forget that a nation can and should be judged on the manner in which it cares for its elderly. Thank you.

Senator BRADLEY. Thank you very much, Dr. Gross.

Our next witness will be Ms. Pat Freeman, legislative chair of the Monmouth Older Women's League.

Welcome to the Committee.

STATEMENT OF PAT FREEMAN, LEGISLATIVE CHAIR, MONMOUTH COUNTY CHAPTER, OLDER WOMEN'S LEAGUE

Ms. FREEMAN. Thank you.

Good morning, Senator Bradley. My name is Pat Freeman, legislative chair of the Monmouth County Chapter of the Older Women's League, the first national membership organization focused exclusively on midlife and older women. Key times or OWL's national agenda are access to health care and related long-term care issues, including support for caregivers and alternatives to institutionalization.

Since midlife women provide most of the homebased uncompensated care, and since poor elderly women are those most in need of homebased care, we welcome this legislation which clearly defines, expands, and improves the quality of home health care currently available under Medicare.

Because she did not meet the numerous tests set up by the Health Care Financing Administration to qualify for home health care under Medicare, one of our terminally ill members was denied the dignified death she deserved. Her family did their best to make her comfortable, but she needed skilled nursing care after her premature discharge from the hospital. She died in extreme pain and angry with those close to her.

Hopefully, cases like this will be eliminated when this legislation is passed into law.

Too often the needy are disqualified for home care because of the restrictive interpretations of two requirements—that a person be "homebound" and need "skilled care" on an "intermittent" basis.

Clear definition of "homebound" will eliminate the inconsistent interpretations by Health Care Financing Administration. This legislation defines homebound as a condition restricting a patient's ability to leave home without support.

This bill will permit patients to receive home care services under Medicare on a daily basis for up to sixty days and longer when a physician certifies that exceptional circumstances require further care.

We applaud the bill's proposed expansion of coverage to include non-skilled care for three weeks after a patient is released from the hospital and occupational therapy to assist a patient to regain independence. These benefits would be particularly beneficial for women who live alone and need short-term transitional post-hospital care.

This bill requires that standards be set to certify the equality of care being provided by the home health care provider, and calls for formal training for home health aides. Despite a wide range of responsibilities, these providers often receive little or no training and very little compensation. Upgrading these jobs will not only improve the quality of care being provided, but it should improve the income received by these providers—many of whom are midlife or older women struggling to eke out a living.

This legislation comes at a time when the elderly are being discharged from the hospital sicker than ever before and it should be passed by Congress without delay. The New Jersey members of the Older Women's League commend Senator Bradley for introducing this bill and we urge him to continue to fight for home care services for the long-term care needs of the elderly.

Senator BRADLEY. Thank you very much.

Let me thank the entire panel. If I could ask you a few questions now. I'd like to address the first question to Dr. Gross; the Medicare coverage definition of "homebound" basically has been the same for 22 years, since the beginning of the program.

How has HCFA been able to use their requirement to exclude increasing numbers of patients from home care just in the last few years?

We have a situation where for many years the definition was perfectly adequate. No one seemed to have sizeable complaints. Then in the last few years, using the same definition, the federal agency has denied home care to thousands and thousands of people. How, in your view, did that happen?

Dr. GROSS. I think right now the pressure that appears to be placed upon the HCFA intermediaries is a search for ways to be cost effective and not patient effective.

And certainly, from the manual itself, the actual definition of "homebound" appears to be satisfactory; yet, despite the definitions they are denying benefits because a patient may not be homebound.

A clearer example, we can say, from the coverage of service in the Medicare manual, it could be a patient, for example, who has arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity. That's under number 5 of a patient becoming homebound.

These very same patients ten years ago would be considered to be homebound, yet now those same patients are considered to be able to walk outside of the house maybe five minutes, ten minutes, to go to a barbershop, visit a friend, and then be restricted back to the home due to shortness of breath.

They're considering that same patient able to function outside of the home when it's only five minutes outside the home. I think they're looking at any individual who can make it outside the home, be them carried, put into a wheelchair, in any shape or form being outside of that home means no longer homebound, and I think they need to understand what their own definitions are.

Senator BRADLEY. So, what you're saying is that there has been a much tightened interpretation of the regulation.

Dr. GROSS. Not only tightened. I think misinterpreted.

Senator BRADLEY. Misinterpreted.

Ms. Savage, can you lend us any insight as to why, and have you found the same problem?

Ms. SAVAGE. Yes, I would have to agree with Dr. Gross.

I've been in the home care field since 1965, when Medicare was introduced, and it seems that it's only in the last year that homebound regulations have been re-interpreted severely.

Several examples: One woman who was so uncomfortable that she was only comfortable lying down and needed a procedure to relieve her discomfort was judged not homebound, because she was not in excruciating pain. She was only in pain. And those were the words used.

That seems grossly unreasonable in light of the current definition of "homebound" and, as you point out, the definition that has been there from the beginning.

Another patient who needed speech therapy after a stroke, and she received it, and she did improve. Her daughter moved in to help care for her. She was a woman who had problems with her feet and couldn't even get shoes on, could only wear slippers, had great difficulty getting out; only went to the doctor for specific tests, otherwise the doctor made home visits.

She was—we were denied the total amount of the service in that she was not homebound because the fiscal intermediary stated that her family, if they tried hard, could get her out, even with her slippers on.

And, you know, that—it seems in light of the history of Medicare, it seems that there is a need now to look for anything to deny visits so that money can be saved. Very clearly different from Medicare's original intent.

Senator BRADLEY. So, you have a definition for homebound that's been there for 22 years. You then have the Congress pass the DRG system that is supposed to improve efficiency in hospitals, and it has the effect of having many citizens—in this case senior citizens—leave the hospital sooner than they would in the past. That increases demand for home care services.

Because it increased demand for home care services, it increased the costs. HCFA then arbitrarily chooses to say that the law means something other than what it says very clearly in black and white.

They choose to do that, for example, by saying homebound means that somebody has to be in their bed; that they can't be going to the hospital for chemotherapy, or going out for 5 minutes because they're a heart patient. Any of those problems would require, HCFA says, them being disallowed Medicare coverage.

As a result of a hearing that was held last year, the homebound problem came up; we've addressed it in legislation. It is, I think,

going to pass the Senate this week. So, we will change the definition and make explicit what was clear to everyone.

So, are there any other tricks, Ms. Savage, that we ought to look for that this federal agency is using to deny seniors home care?

Ms. SAVAGE. Well, the other point, certainly the intermittent care redefined, I think, is vitally important.

When someone needs care every day of the week, every day is seven days, not five days. And it—we've had situations where patients had very, very large dressings that needed to be—definitely needed the care of a skilled nurse and could not be taught at that point to anyone else.

To say that we can only do that five days because seven days becomes not intermittent is ignoring the fallacy that there are seven days in the week.

And the other thing is for Medicare to say that this person shouldn't have been brought onto service, perhaps they should be in an institution, seems to go against all that we've been trying to do in terms of supporting people at home, in terms of the cost effectiveness of having someone at home recovering rather than in a hospital or a nursing home.

So, it seems——

Senator BRADLEY. Intermittent care?

Ms. SAVAGE. That definition is also going to be vitally important.

Senator BRADLEY. Well, let me ask you, since we have the situation where there are appeals of denials: Have the home health agencies in your organization had much luck in reversing home care denials through appeals?

Ms. SAVAGE. Well, there are several levels of appeal, and we find that the most successful level is the Administrative Law Judge.

If a case is taken that far, there has been an overwhelmingly high percentage of reversals of the decision.

Senator BRADLEY. What are the levels of appeal, just for the record?

Ms. SAVAGE. Well, there are—there's an informal reconsideration. If an agency is covered under the waiver of liability and is denied service, an informal reconsideration, the reports from the agencies, and in my own experience, have been that almost never or rarely is a decision reversed at that level.

Then there is the more—if an agency is off the waiver of liability, which most agencies are now with these restrictive denials, then there can be a formal appeal.

This again, most decisions of the intermediary are upheld. It's only when agencies go beyond that—sometimes at great expense, both of money and time—to the Administrative Law Judge that there has been a favorable decision for the agencies.

There seems to be a greater understanding of patient need.

Senator BRADLEY. How long does it take on average for intermediaries to hand down an appeal of reconsideration?

Ms. SAVAGE. That has varied from anywhere from several months to three to four months or longer, depending on the case.

Senator BRADLEY. So, what happens is, a senior citizen thinks they deserve home care; they're disallowed home care; they appeal, and you say it can go on as long as four to five months before they know if they're going to be covered under Medicare.

So that they are, in essence, without any means to pay for care for four to five months.

Ms. SAVAGE. That's correct. And the agencies are required to foot the cost of this care during that initial period. And that's becoming a great burden for many of our agencies.

The care often is rendered in good faith and with often very good results; and later we are told that that's denied.

Senator BRADLEY. May I ask, Ms. Freeman, what would you say are the special problems of elderly women living alone?

Ms. FREEMAN. They're afraid they're going to live too long.

At one time it used to be quite wonderful to look forward to old age. Daughters and daughters-in-law would be normal home care givers but now 50 percent of the women in New Jersey are working. So, that's no longer available.

They don't want to be a burden on other people. They want to be able to make it on their own. They don't want to be impoverished by having a spouse put in an institution. I think that's a big worry.

Senator BRADLEY. Spousal impoverishment?

Ms. FREEMAN. If one member of a couple needs to be put in a nursing home, often they have spend down, to the Medicaid level, the income of both. And many times it leaves the spouse who is not in the institution impoverished.

Senator BRADLEY. So if you have an elderly husband and wife, one is very sick, and they don't have jointly enough money to cover the cost of home care, they must spend down their money in order to reach Medicaid level so that the one spouse can go into an institution and be paid under Medicaid?

Ms. FREEMAN. Right.

Senator BRADLEY. And then it leaves the other spouse outside the institution destitute.

Ms. FREEMAN. Yes.

And often the spouse who needed the care dies, and we have an impoverished woman, who for the rest of her life is dependent on the State.

Senator BRADLEY. Well, I can tell you that the bill will deal with that, and I hope we'll be able to get that passed in September.

Ms. FREEMAN. Good luck.

Senator BRADLEY. Let me ask you just one last question, Ms. Freeman, and that is, what about elderly women living alone? What happens if that person doesn't qualify for Medicare and home health benefits?

Ms. FREEMAN. I guess she just has to depend on insurance or friends or Medicaid.

Senator BRADLEY. As you said, we have a lot of elderly that need care; then we have the providers, the people who come in and take care of the elderly. In many cases they are elderly themselves.

Ms. FREEMAN. Exactly.

Senator BRADLEY. What are the special problems of these elderly caregivers?

Ms. FREEMAN. Well, at an age, say, in their 60's, they expect to be able to take it a little easy, and then they find that their 90-year old parent needs help. And they just have to fill in and do their best to take care of them. That's about the way it stands.

There isn't any other help—the uncompensated caregivers provide 75 percent of the home care right now. The average age of a caregiver is 57. We find many instances of the old taking care of the older.

Senator BRADLEY. If I could just ask one last question.

There is a problem on the definition of homebound and a problem of a limited number of days of homecare. Is the latter a serious problem, Doctor?

There are cases where people get home care, but because it only lasts a very short period of time, they're not able to combat their illness.

Dr. GROSS. That's a major issue. In our emergency room, each week there are many patients that are back in the emergency room only discharged two or three weeks before. And we often ask why they're here again.

What happened, we find out they did not qualify for home health care. Be it for bed sores that were neglected over a weekend because they were only covered for five days, not the sixth and seventh day. When the home care agency comes back on a Monday, that bed sore is now as deep as it was when they first picked up the case.

So, these patients come back to the hospital, often need re-admission. The re-admission rate is high, and they're paying for it when they could have saved money by providing it at home.

This is a serious problem that needs attention.

Senator BRADLEY. One of the provisions in the catastrophic bill that extends the number of days of coverage from 2 weeks to 45 days would mean, according to the Congressional Budget Office, that 280,000 senior citizens in the country would get home care who now do not get home care. And 10,000 of those senior citizens would be in New Jersey.

So, as a result of that provision that extends simply from two weeks to 45 days, the time you can get home care under Medicare for acute situations, you'd get 10,000 more New Jerseyans covered.

That's largely because of your help in calling my attention to that problem that this is going to happen. I thank the panel very much for your testimony; I think you've helped a great deal.

Thank you.

Now, our next panel will deal with home care quality. Our witnesses are Esther Abrams, Chairwoman, New Jersey State Legislative Committee, American Association of Retired Persons; Kenneth Nolan, Director of Home Care Council of New Jersey; and Philip Pearlman, President, New Jersey Association of Area Agencies on Aging.

Let me welcome the panel to the hearing and tell you that we're looking forward to your testimony.

And let me say a special word of welcome to Ms. Abrams for your hard work in helping to assist us in putting together the Home Health Improvement Act of 1987.

Can we have order, please, and let's begin with Ms. Abrams.

STATEMENT OF ESTHER C. ABRAMS, CHAIRWOMAN, NEW JERSEY STATE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. ABRAMS. Senator Bradley, my name is Esther Abrams, and I'm honored to testify on behalf of the American Association of Retired Persons, 26 million members.

I am presently chairwoman of AARP's New Jersey State Legislative Committee.

AARP is deeply grateful to you, Senator Bradley, and other members of the Aging Committee for sponsoring this important piece of legislation which is the product of our joint efforts. As you know, AARP has endorsed this bill and we are committed to its enactment.

Our concern about Medicare beneficiaries' access to home health services they are entitled to, as well as the quality of the care they do receive, arises from many sources.

We are concerned about data showing rising denials of home health claims. Despite evidence of increased need for this service, expenditures for this benefit have not kept up with need.

The increasing need for home health care is due in part to changing patterns in health care delivery and reimbursement. While the Department of Health and Human Services has yet to document the extent to which earlier hospital discharge has increased the need for post acute care, there is every reason to believe this is the case.

We know that the average length of hospitalization has shortened for every DRG and for patients of every age. It is a fact that hospitals are discharging elderly patients quicker and sicker. However, since the implementation of prospective payment for hospital services, the rate of growth in Medicare outlays for home care has dropped sharply.

AARP believes that the Executive Branch is restraining growth, in part, by denying claims for service. In fiscal year 1984, 1.6 percent of claims for home health services were denied. By fiscal year 1986, the claim denial rate had risen to 6 percent and that rate continues to rise.

We are also alarmed by the government's ineffective monitoring and control of providers; lack of national minimum qualifications for home health aides; and the virtual absence of consumer information with which to select a high quality provider.

The provisions of this bill will significantly improve both the access to care problem and the quality of care provided.

It confers on the Secretary of the U.S. Department of Health and Human Services the necessary power to effectively monitor and evaluate compliance with federal requirements. The bill also enhances the Secretary's power to achieve compliance with those requirements. Furthermore, it requires the publication of information about the quality of providers so that consumers and referral agencies can meaningfully select a high quality home health care agency.

We are particularly pleased to support Section 7 of the bill regarding Conditions of Participation of Home Health Agencies. This provision of S. 1076 will go a long way toward improving the qual-

ity of Medicare reimbursed home health services. First, the bill stipulates that only people who have met national uniform minimum training requirements or who are licensed professionals can provide care. This provision will certainly result in improved care provided by home health aides who are now largely untrained and unskilled. Failure to employ qualified personnel will automatically violate a condition of participation in Medicare.

Furthermore, Section 8 of the bill changes the focus of surveys of Medicare providers onto the patient and the quality of care that was actually provided. In our views, that is exactly the proper focus of a compliance survey. By focusing compliance surveys on the outcome of care, this bill helps give substance and meaning to the concept of quality.

That is, by requiring unannounced surveys, patient interviews, use of a standard outcome oriented patient assessment tool, and the imposition of timetables for corrective action—backed up by fines and other sanctions—the Medicare Home Health Services Improvement Act will indeed live up to its title. It will result in improved services to the thousands of beneficiaries who need skilled nursing care at home as well as other supportive and restorative care.

Additionally, the bill offers consumers meaningful information about the quality of care offered by local providers. Without such information, consumers cannot make informed choices and protect their interests. Consumer choice of high quality providers will create positive market forces to improve the overall quality of care by rewarding good performance and penalizing poor performance. In this way, the health and well-being of beneficiaries will be enhanced and we taxpayers will get our money's worth.

In conclusion, I would like to reaffirm AARP's support of S. 1076. We pledge to work for its enactment this year. The improvements to Medicare's home health benefits it offers are both essential and long overdue. The bill represents crisis prevention for an extremely vulnerable population.

Thank you for this opportunity to speak at this hearing on a topic of vital concern to all Medicare beneficiaries and their families. You and the bill's cosponsors are to be commended for taking a leadership role in improving access to quality home health care.

Senator BRADLEY. Thank you very much, Ms. Abrams.

The next witness is Mr. Kenneth Dolan, the Director of the Home Care Council of New Jersey.

Welcome to the Committee, Mr. Dolan.

STATEMENT OF KENNETH R. DOLAN, EXECUTIVE DIRECTOR, HOME CARE COUNCIL OF NEW JERSEY

Mr. DOLAN. Senator Bradley, on behalf of the Home Care Council of New Jersey, I would like to thank you for this opportunity to offer testimony on the Medicare Home Health Services Improvement Act of 1987. I am here today to specifically address the quality assurance aspects of the proposed legislation.

As you are aware Senator, the Council represents the state network of non-profit homemaker-home health aide agencies. For many years, the Council has been a leading advocate in New

Jersey for the establishment of uniform quality assurance standards for homemaker-home aide services. For this reason, we support the quality assurance component contained in your legislation.

In your legislation, you correctly state that Medicare's current quality assurance program for home health care is not adequate because it is limited to what evaluators call "Structural Standards." These are the standards that relate to an agency's legal authority, administration, policies and procedures, staff credentials training, and fiscal management. As your bill points out, structural standards measure an agency's capacity to deliver services rather than the quality of service actually provided.

While requiring the Health Care Finance Administration to develop a quality assurance program which looks not just at structural, but also service delivery processes and service outcomes is the most laudable goal of your bill. It represents a Catch 22 for providers who must cope with the arbitrary and capricious reimbursement methods of HCFA.

Take for example a very straight forward Process Standard. "The Home Health Aide will, under professional nursing supervision, provide personal care services appropriate to the needs of the patient. While this certainly represents a reasonable standard, its applicability must be measured against what is happening in the real world of home care.

The Very Professional Home Care Agency, Inc., is caring for Mrs. Jones, an 85 year old Medicare patient. During the initial assessment visit, the Public Health Nurse determines that Mrs. Jones needs 12 hours/week of home Health Aide Service because her physical condition is so serious that she is unable to do any personal care for herself. Based on the assessment, it is safe to assume that the nurse orders the 12 hours/week of home health aide service? No, wrong. Because of past denials by the fiscal intermediary, the Administrator of Very Professional Home Care Agency, Inc., knows that any order for home health aide service over 6 hours/week will be automatically denied. Since the agency has experienced more than $50,000 in service denials in the past year, it has decided to establish a policy which prohibits nurses from ordering more than six hours per week of home health aide service, regardless of the patient's condition.

Senator, as you are aware, the Medicare Home Health Services Improvement Act proposes that intermediate sanctions for poor quality be established, including civil fines and denial of Medicare reimbursement for future Medicare patients. In the example described above, Very Professional Home Care, Inc., would probably be subject to the proposed fines and sanctions because they failed to meet the standard. Such action would be unreasonable because the lack of compliance with the standard is beyond the control of the agency. Quality assurance is an empty promise for Medicare patients unless HCFA is mandated to link appropriate reimbursement to all required standards of care. We can no longer continue deceiving ourselves by thinking that quality can be assured at no added cost to the public.

I'd like to depart from my testimony—prepared testimony—by saying you mentioned earlier about—asking about the reinterpreta-

tion of certain requirements, the homebound requirement and intermediate care.

Well, the home health aide industry was first impacted by reinterpretation of the rules and requirements back in 1981. It used to be pretty standard in the industry that an agency could order up to 20 hours a week of home health aide services as needed.

In 1981, the Health Care Finance Administration changed the regulation, rewrote what they call the language clarification; and in doing so, they basically more than halved the—it went from 20 hours a week down to 10 hours a week, and now it's been cranked down to 6 hours a week.

In New Jersey today we have on an average of about, I would say, 60 to 70 percent of all homemaker home health aide services provided to Medicare patients are 6 hours a week or less. And that's because of HCFA denying anything more than that.

Now, the regulation says that more home health aide services can be provided, if needed. But HCFA has chosen to tell its intermediaries that it's never needed, basically. So, in almost every case, the agency, the certified homemaker health agency, in order not to go bankrupt, they make sure that they don't provide more than basically what has been a maximum of six hours per week.

I'd like to go on to training requirements.

It is an accepted fact that the quality of home health care services is adversely affected by the fact that there are no federal requirements regarding training or proficiency requirements for home health aides.

Senator, as you are aware, here in New Jersey, the Department of Health has for many years required that all home health aides caring for Medicare patients must be State certified. To be certified, aides must complete a 60-hour training course approved by the Department of Health.

The aide certification requirement is also part of the accreditation standards of the Commission on Accreditation for Home Care. Homemaker-Home Health Care agencies must be accredited by the Commission before they can qualify as providers in the State's Community Care Program for the Elderly and Disabled and the Medicaid Personal Care Assistant Program.

Unfortunately, New Jersey is currently facing a major crisis in providing adequate long-term home care services because of the growing shortage of home health aides. A recent survey of the Council's member agencies revealed that on any given day, each agency has an average of 25–30 patients who are not receiving service because of a shortage of trained aides. By projecting these averages to the entire home health care industry in New Jersey, it is estimated that between 1,500 and 2,000 patients do not receive or are delayed services on any given day because of aide shortages. Further, it is estimated that an additional three to four thousand patients receive less than the optimal amount of service because providers frequently reduce the amount of service to each patient in order to serve more patients.

Based on feedback we have received from other states, the home health aide shortage crisis is clearly a national problem. This problem will only be exacerbated if training and proficiency requirements are strengthened without requiring corresponding improve-

ments in the compensation, public status and job satisfaction of home health aides.

I've been in this business for 15 years, and frequently I've seen that while we have a solution to one problem, it creates a lot of other problems. All we have to do is look at the nursing shortage in this country.

Back 10, 15 years ago, nursing educators in this country said that what all nurses need to be is more trained. So, through the American Nurse's Association and their affiliate state units, nurses said we don't have all trained nurses or at least associate degree nurses.

They are trying to phase out the diploma program, because they said we need higher trained nurses. Well, the outcome of that has been we have a major shortage in nursing. My wife is an administrator in a hospital, and her biggest problem in terms of quality care isn't the training or quality of the nurses she hires. It's covering the units because of the shortages.

Now, we have a problem here with aide shortages, and I'm a little concerned that if we don't address it—if we just look at it that everybody meets certain standards of training proficiency, without looking at the other half of the equation, which is status, payment, we're going to further exacerbate the problem.

[The prepared statement of Mr. Dolan follows:]

PREPARED STATEMENT OF KENNETH R. DOLAN

Senator Bradley, on behalf of the Home Care Council of New Jersey, I would like to thank you for this opportunity to offer testimony on the Medicare Home Health Services Improvement Act of 1987. I am here today to specifically address the quality assurance aspects of the proposed legislation.

As you are aware Senator, the Council represents the state network of non-profit homemaker-home health aide agencies. For many years, the Council has been a leading advocate in New Jersey for the establishment of uniform quality assurance standards for homemaker-home health aide services. For this reason, we support the quality assurance component contained in your legislation.

We do however, have some concerns regarding quality assurance in home care which we would like to bring to your attention. Quality Assurance is not a theoretical concept, something that can be just plugged into the home care system and simply monitored by federal and state regulators. Quality assurance is affected by a multitude of factors including; reimbursement methodologies, consumer education, profit motives and public perceptions.

In your legislation, you correctly state that Medicare's current quality assurance program for home health care is not adequate because it is limited to what evaluators call "Structural Standards". These are the standards that relate to an agency's legal authority, administration, policies and procedures, staff credentials training, and fiscal management. Structural standards measure an agency's capacity to deliver services rather than the quality of service actually provided.

The Medicare Home Health Services Improvement Act would require the Health Care Finance Administration to develop what are termed Process and Outcome Standards for Medicare certified home care providers. Process Standards contain criteria used to evaluate the actual process of delivering care including; service protocols, supervision requirements, and staffing requirements.

Outcome Standards, while simple in concept, are much more difficult to develop and measure. The quality of an agency's service cannot simply be measured by whether or not the patient fully recovers because of the many variables involved. Such factors as: disease chronicity; adequate housing; family and informal support systems; and personal resources; frequently play an equal or greater role in the patient's ability to recover than do health care interventions.

While requiring the Health Care Finance Administration to develop a quality assurance program which accurately evaluates the quality of home health care provided is a most laudable goal, it represents a Catch 22 for providers who must cope with the arbitrary and capricious reimbursement methods of HCFA.

Take for example a very straight forward Process Standard. "The Home Health Aide will, under professional nursing supervision, provide personal care services appropriate to the needs of the patient. While this certainly represents a reasonable standard, its applicability must be measured against what is happening in the real world of home care.

The Very Professional Home Care Agency, Inc., is caring for Mrs. Jones, an 85 year old Medicare patient. During the initial assessment visit, the Public Health Nurse determines that Mrs. Jones needs 12 hours/week of Home Health Aide Service because her physical conditions is so serious that she is unable to do any personal care for herself. Based on the assessment, is it safe to assume that the nurse orders the 12 hours/week of home health aide service? No, wrong! Because of past denials by the fiscal intermediary, the Administrator of Very Professional Home Care Agency Inc., knows that any orders for home health aide service over 6 hours/week will be automatically denied. Since the agency has experienced more than $50,000 in service denials in the past year, it has decided to establish a policy which prohibits nurses from ordering more than six hours per week of home health aide service, regardless of the patients condition.

The Medicare Home Health Services Improvement Act proposes that intermediate sanctions for poor quality be established, including civil fines and denial of Medicare reimbursement for future Medicare patients. In the example described above, Very Professional Home Care, Inc. would probably be subject to the proposed fines and sanctions because they failed to meet the standard. Such action would be unreasonable because the lack of compliance with the standard is beyond the control of the agency. Quality assurance is an empty promise for Medicare patients unless HCFA is mandated to link appropriate reimbursement to all required standards of care. We can no longer continue deceiving ourselves by thinking that quality can be assured at no added cost to the public.

It is accepted fact that the quality of home health care services is adversely affected by the fact that there are no federal requirements regarding training or proficiency requirements for home health aides. Senator, as you are aware, here in New Jersey, the Department of Health as for many years required that all home health aides caring for Medicare patients must be state certified. To be certified, aides must complete a 60 hour training course approved by the Dept of Health.

The aide certification requirement is also part of the accreditation standards of the Commission on Accreditation for Home Care. Homemaker-Home Health Aide agencies must be accredited by the Commission before they can qualify as providers in the State's Community Care Program for the Elderly and Disabled (Medicaid Waiver) and the Medicaid Personal Care Assistant Program.

New Jersey is currently facing a major crisis in providing adequate long-term home care services because of the growing shortage of home health aides. A recent survey of the Council's member agencies revealed that on any given day, each agency has an average of 25–30 patients who are not receiving service because of a shortage of trained aides. By projecting these averages to the entire home health care industry in New Jersey, it is estimated that between 1,500 and 2,000 patients do not receive or are delayed services on any given day because of aide shortages. Further, it is estimated that an additional three to four thousand patients receive less than the optimal amount of service because providers frequently reduce the amount of service to each patient in order to serve more patients.

Key factors which have contributed to the current aide shortage crisis in New Jersey include:

Availability of comparable work with better compensation—as the economy has continued to improve more job opportunities have opened up in the service sector. In N.J.'s booming economy, there is strong competition for entry level workers.

The domestic image of home health aides—the general public's misconception of the role of home health aides makes it difficult to pay competitive wages and benefits and to recruit enough dedicated and committed workers.

A high attrition rate—the lack of career mobility, job appreciation, and support by supervisory and management staff create low job satisfaction among many home health aides.

Based on feedback we have received from other states, the home health aide shortage crisis is clearly a national problem. This problem will only be exacerbated if training and proficiency requirements are strengthened without requiring corresponding improvements in the compensation, public status and job satisfaction of home health aides.

Senator Bradley, over the next 10–15 years our nation will be facing the tremendous challenges presented by the "geriatric imperative." It is important that we rethink our traditional approaches to delivering home health care service and assur-

ing its' quality. New coalitions and or cooperative arrangements between private sector providers, purchasers of service, consumers, and government regulators will be required in order to assure the highest quality service. Quality of care can not be assured unless there is a commitment by all parties involved.

Senator BRADLEY. Thanks very much, Mr. Dolan, for your testimony.

Now, we'll go to Mr. Philip Pearlman, President of the New Jersey Association of Area Agencies on Aging.

Welcome to the Committee, Mr. Pearlman.

STATEMENT OF PHILIP H. PEARLMAN, PRESIDENT, NEW JERSEY ASSOCIATION OF AREA AGENCIES ON AGING

Mr. PEARLMAN. Thank you, Senator. Thank you, also, for allowing me to be here today and offering testimony on behalf of the 21 county offices on aging in New Jersey.

As you know, area agencies on aging are vitally concerned about all issues which affect the well-being of senior citizens. High among these concerns is the issue of quality, particularly in home care. From the perspective of area agencies on aging, the issue of quality in home care focuses on access, cost, funding duration, the available supply of home care aides, the training of these home care aides, the ambiguous regulations of HCFA, the need for more social models of home care and the role of various agencies on aging in New Jersey regarding home care.

The historic and mandated service of information and referral has become more important as elderly persons and their families seek home or community based care. The increased need and demand for home care brings many people who are unaware of available services to the information and referral units of various agencies on aging.

Various agencies on aging could also provide coordination of home and community based care services by bringing providers of home delivered meals, adult day care, home health aides, homemakers and chore service together to improve access for clients needing service.

The ability of area agencies on aging to provide information and referral coordination access and receive consumer input puts them in a position to assist in measuring and monitoring the quality of home care. I'm not suggesting that area agencies on aging could or should be directly involved in monitoring the quality of home care. Rather, I am suggesting they have a great deal of information which can be used by a regulatory body.

The area agencies on aging in New Jersey support S. 1076 wholeheartedly. The issue of quality in-home care is one that has long been overlooked and we applaud Senator Bradley's efforts to address the issue. If we can assist in efforts to improve any service for the elderly, we are available and ready.

I thank you for allowing me to be here today.

The prepared statement of Mr. Pearlman follows:]

PREPARED STATEMENT OF PHILIP H. PEARLMAN

Thank you for allowing me to be here today and offer testimony on behalf of the 21 county offices on aging in New Jersey. My name is Philip Pearlman. I am president of the New Jersey Association of Area Agencies on Aging [NJ4A] which is the statewide organization representing the twenty-one county offices on aging.

As you know, area agencies on aging are vitally concerned about all issues which affect the well being of senior citizens. High among these concerns is the issue of quality, particularly in home care. From the perspective of area agencies on aging, the issue of quality in home care focuses on access, cost, funding duration, the available supply of home care aides, the training of these home care aides, the ambiguous regulations of HCFA, the need for more social models of home care and the role of A.A.A.'s in New Jersey regarding home care. Let me elaborate on each of these a bit more.

ACCESS

For a person who has never used home care, finding an agency can often be a problem. In some areas there is little choice because there are few agencies, in other areas there is a wide choice which may include independent contractors and agencies purporting to provide home care but are really employment agencies with no commitment to quality home care. The uninitiated consumer who expects standards and ethics to be built into the system has no way of knowing these standards and ethics may or may not exist.

A person needing home care who does not have the ability to pay full or part fees may have their access problem compounded when trying to find an agency who has public funds (i.e., Older Americans Act or title XX). The referrals available from hospital discharge planners or A.A.A.'s may not be known widely enough in an area to ease or eliminate this problem. Coordinated home care systems in each county would help resolve both these access problems.

COST

Individuals of modest means are hard pressed to provide adequate home care for themselves. The cost of home care has been constantly rising over the years, as you are well aware. The increasing demand for home care seems to outstrip the industry's ability to meet the demand which creates a seller's market. A direct relationship between cost and quality which may be assumed to exist by consumers but is in fact non-existent is also a problem. The need to establish basic standards to insure quality home care is therefore of increasing importance.

FUNDING

The restrictiveness of Medicare in providing home care has quantitative and qualitative implications. The limitations based on intermittent care and allowable hours of service have a direct bearing on the quality of care a patient can receive.

There are at present at least two categories of Medicare patients who are being disserved. One is the patient who requires additional service during the period Medicare covers them for home care. The other category is patients who require home care beyond the period of Medicare eligibility. For both categories, there is usually a lack of alternative funding to serve those who cannot afford to provide for their own care. A.A.A.'s are often hard pressed by agencies who request O.A.A. funds for home care to serve these Medicare patients and the patients themselves who are seeking alternatives to Medicare and contact the I&R units of A.A.A.'s.

AVAILABLE SUPPLY OF HOME CARE AIDES

One of the basic problems in the provision of adequate home care is the availability of home care aides, particularly those who are trained and certified. There are never enough aides to meet the total demand and the attrition rate keeps growing. I believe one of the major reasons for the high attrition is the relatively low wage scale and lack of fringe benefits for most home care aides. Very few agencies provide salary and fringes. Most agencies pay hourly wages with no fringe benefits. To treat home care aides, the cornerstone of home care in this fashion can only continue to exacerbate the problem of providing adequate, quality home care.

The training needs of the home care industry are another problem which must be addressed. If home care training and certification were offered as part of the regular curriculum of vocational schools and county colleges the training would be more accessible to more people. The attractiveness of the home care aide job would also improve if it were viewed as para-professional which institutionalized training and certification could achieve.

HCFA REGULATIONS REGARDING HOME CARE

We agree wholeheartedly with Senator Bradley's statements about the present arbitrary and ambiguous regulations promulgated by HCFA relating to Medicare and home care. The confusion on defining "intermittent" and the preclusion of patients who would need more than 3 weeks of skilled nursing care are two examples of the arbitrary and ambiguous regulations.

The present tendency of hospitals to discharge patients "quicker and sicker" based on the DRG system of payment to hospitals without enhanced home care coverage by Medicare is also a disservice to the elderly. The cost saving benefit of the DRG system should be rechanneled into home care if Medicare is to be what it was intended to be.

Lastly, in regard to this point I would like to underscore the basic flaw in Medicare which is the focus on acute care with no recognition of the need for long-term care. With the dramatic increase in the numbers of elderly people, particularly the "old old," Medicare must address the need for long-term care.

NEED FOR ADDITIONAL MODES OF HOME CARE

In addition to improving and expanding the conventional homemaker/home health aide service component of home care, we need more adult day care (both medical and social models), chore service, home repair service and emergency response systems. All of these services in sufficient quantities and of high quality are important if we as a society believe that living options of elderly persons should not diminish as age advances.

ROLE OF A.A.A.'S IN NEW JERSEY REGARDING HOME CARE:

The historic and mandated service of information and referral [I&R] has become more important as elderly persons and their families seek home or community based care. The increased need and demand for home care brings many people who are unaware of available services to the I&R units of A.A.A.'s.

A.A.A.'s can also provide coordination of home and community based care services by bringing providers of home delivered meals, adult day care, home health aides, homemakers and chore service together to improve access for clients needing service.

The ability of A.A.A.'s to provide I&R, coordination, access and receive consumer input puts them in a position to assist in measuring and monitoring the quality of home care. I am not suggesting that A.A.A.'s could or should be directly involved in monitoring the quality of home care. Rather I am suggesting they have a great deal of information which can be used by a regulatory body.

The A.A.A.'s in New Jersey support S. 1076 wholeheartedly. The issue of quality in home care is one that has long been overlooked and we applaud Senator Bradley's efforts to address the issue. If we can assist in efforts to improve any service for the elderly, we are available and ready.

Again, thank you for allowing me to be here today and testify on behalf of the A.A.A.'s in New Jersey.

Senator BRADLEY. Mr. President, thank you very much. And I'd like to thank the whole panel.

I think this has been a very helpful panel, because it's dealt with a couple of very important issues in a way that I think will lead to an interesting discussion.

Let's focus on training. Home health aides that come into the home of an elderly person, in many states, have never had one day of training. One day of training as to what the job is, what kind of qualifications or what kind of qualities are important, et cetra.

In the bill that I've introduced, it makes it a Federal requirement that home health agencies provide for some training prior to sending a home health aide into the home of senior citizens.

My question to you—and I'd like to have Mr. Pearlman and Mr. Dolan comment on this—do you think that requiring homemaker home health aides to complete a training course could raise the status of the position?

In other words, if you have to have a certain training course, you assume that there's a higher level of awareness and competence. Do you think that it would raise the status and that in and of itself might allow aides to get higher salaries?

Mr. DOLAN. I don't think so. And I could tell you why, because in New Jersey, as I said, New Jersey does have the requirement that all aides working in Medicaid and Medicare must be certified. It's a requirement since the early 70's. It has not, I don't think, measurably helped the status of the aide.

In fact, that's why right now our agencies—that's why right now our agencies are having a problem getting aides, because of the status issue. When they're faced with a situation where when they go into a home some of their patients refer to them as "my girl" and that's a public education issue. And when we get to the issue where Medicaid, like a personal care assistant program, will only reimburse a flat rate, you're—the provider's kind of locked into a certain reimbursement.

It could not increase the aide's salary because of the fact that nobody's going to pay for that increase in salary. So, I think that's why I mentioned earlier, I think it needs to be tied together. We have to work at ways, just like I know, Senator, you've been gracious enough to share with your time every year to come to our Home Health Aide Day where the Governor has proclaimed one day of the year—last year it was May 18th—as Homemaker Home Health Aide Day; and we honor aides throughout the state for their—what they've done.

Senator BRADLEY. So you say no, you don't think so.

What about you, Mr. Pearlman?

Mr. PEARLMAN. Well, Senator, in my complete testimony, which I've submitted to you, I suggested that the training of homemaker home health aides, if it were more institutionalized in terms of vocational schools and county colleges, might help to elevate the public's perception of these people.

They really are the heart of the home care system; and yet, they're really not thought of as being para professionals.

And if we could cultivate how the public perceives them, as Mr. Dolan said——

Senator BRADLEY. So, you disagree with Mr. Dolan. You think that it would help?

Mr. PEARLMAN. I think it would help.

Senator BRADLEY. Let me ask you, Mr. Dolan, what are your suggestions about how you can ensure competency of these workers that go into the homes of senior citizens?

Mr. DOLAN. Well, I'm not—let me explain. I'm not saying we shouldn't have training.

Senator BRADLEY. Oh. So, you do support training.

Mr. DOLAN. I support training; but what I'm saying is——

Senator BRADLEY. And you support it being a federal requirement?

Mr. DOLAN. I support it being a federal requirement, but I also want to have the bucks behind it.

You can't require providers to do certain—change the way they do business without also providing the wherewithall for them to do that. And I know the Home Care Finance Administration has been

very reluctant to reimburse for services at the appropriate levels. And I see this happening—this is what happened. I can see the standards being in place, the training requirement being there, but not the dollars there to support that requirement. And that's all I'm saying.

And I don't know how you get HCFA to pay for what it's requesting. So, I'm very much in favor of——

Senator BRADLEY. Would you be in favor of mandating that cost to the states?

Mr. DOLAN. The states picking up that cost?

Senator BRADLEY. Yes.

Mr. DOLAN. Yes, I would say that. Yes.

Senator BRADLEY. Okay. Let me ask Ms. Abrams, do you think that if you were publishing quality information for selecting your home care agency in a directory, for example, of home care agencies, do you think people would actually refer to the directory in order to see which ones had had problems with quality? Do you think that a directory is a consumer item that would help people shop for a home care agency?

Ms. ABRAMS. I believe it is.

I would like to say that our main priority of the State Legislative Committee this year is to try to work to achieve state regulation of the proprietary agencies that are providing. And I feel that this is a huge problem.

If you take a place like Princeton, where I live, there's a lot of home care agencies out there where there's absolutely no way of knowing who's going to send a good care provider and who isn't going to send a good one. There is no way at this point.

So, I think that there should be very clear regulation of those agencies, but also information given to the public.

Senator BRADLEY. Well, tell me—and I'd like to have Mr. Dolan and Mr. Pearlman comment on this, as well—in the current situation, how does a senior citizen decide which home care agency he or she should go to?

You said you're in an area where there are a lot of choices. How would a person go about deciding that?

Mr. DOLAN. Well, one thing, of course, is the State Division on Aging now has an 800 number which people can call and ask for information, but I don't know whether they're able to do something like that. You'll have to ask Phil Pearlman.

Mr. PEARLMAN. It is possible that someone can call the 800 number or call the county office and they would be able to get information about what services were available. And in some countries, there is a wider choice than in others.

I'm from Union County. We have a wide choice. We have at least six certified home care agencies who are members of the Council. So that, there is a lot of choice.

In some of the more rural counties, the consumer doesn't have that great of a choice. So that, it really depends on where you live.

Senator BRADLEY. Let me ask you, have the options for home and community based care for the elderly grown in the last few years? Have they increased in number, in your opinion, or have they actually become more limited?

Mr. PEARLMAN. Are you asking me, Senator?

Senator BRADLEY. I'd like Mr. Pearlman and Ms. Abrams to answer.

Mr. PEARLMAN. There has been some growth, particularly in home health care and in some of the direct services of home care; but, frankly, it's not through the best efforts of Medicare, nor Medicaid. It's for the auxiliary kinds of funding that come through county offices, Title XX, which is now called Social Services Grant. More and more of these funds are being dedicated to fill these gaps, because it hasn't been available to start resources of Medicare——

Senator BRADLEY. So you say that yes, you do think that there are more options for the elderly, but those options have come from other federal programs. They've come from programs like Title XX and not through the Medicare Program?

Mr. PEARLMAN. Exactly. So, it's coming from programs that were not originally designed specifically to provide home care or health care even, but rather, more of a broader array of social services.

Senator BRADLEY. I don't know what that tells you, but that tells me there is a very large demand——

Mr. PEARLMAN. Absolutely.

Senator BRADLEY. And when it's not provided through one channel, the Medicare channel, it seeks satisfaction in other areas. If there's a need and you can't do it out of Medicare, you try to find a way to do it out of other funds, which sometimes, as you point out, is not the original purpose of those programs.

Pat, do you have any comment on that?

Ms. ABRAMS. My only comment is this is why we're concerned about some sort of regulation of these—of provider agencies, particularly the proprietary ones, because I think they're going very fast.

And frankly, I've been working with Ken Dolan, and I'm trying to develop something legislatively for the State that would regulate these agencies. I think they're filling a void.

Senator BRADLEY. I think that brings us to the next point of this discussion, which is of paramount importance to anybody who has worked in this field, and that is, how can you assure quality? We're talking about home care, and who should get coverage and should you expand the coverage to a certain number of days.

One has to make sure that when the coverage is provided and the care is provided, that it's quality care. And one of the things that we've looked at is the idea of training, and the other is holding the agency accountable.

And we have—as you pointed out, Mr. Dolan, in your testimony, a way of doing it now that is more a measurement of process and structure; and what we're proposing in this legislation is that it be more on the basis of outcomes.

Can any of you think of a more effective way to measure quality, other than outcomes?

Mr. DOLAN. I can't. I mean, outcomes is—in evaluation circles for quality care, outcomes is ideal. Among evaluators, quality assurance evaluators, outcome measures are always considered the optimum ones.

The problem with outcome measures is an area—especially when you're talking about chronic illness, long-term disability, outcome

measures are a little more difficult to develop because of the other variables involved.

I mean, a person who is 85 years old and has a chronic disability, such things as adequate housing appropriate informal support systems and other service networks are as important, if not more important, than the health care intervention. And so, to put the entire burden on one part of the equasion, just on the health care provider, and ignoring the fact that the federal government has cut back on housing and there isn't adequate housing now for a lot of seniors, I mean, these buildings aren't built anymore. There isn't federal funding for this type of building anymore.

And I'd like to know the people in New York City who live in a crime ridden area, where are they going to go when they turn 70, 75 years old? And what I'm saying is that outcome measures can, too, work both ways.

I mean, we could develop, I think precise outcome measures; but——

Senator BRADLEY. So you're saying yes, even with all of the problems, you say there's no better measure than outcomes, and you'd like to work with an outcome standard rather than the process standard. No matter how many Ph.D.'s or Master graduates or college graduates you have in your program, what systems you have, et cetera, et cetera, the outcome is better than the structure or process measure.

Mr. PEARLMAN. Absolutely.

Senator BRADLEY. Does everybody agree with that?

Ms. ABRAMS. Yes.

Mr. PEARLMAN. Yes.

Senator BRADLEY. So then, Mr. Dolan's point is, you just have to do the outcomes standard in a way that takes into consideration some of complexities.

But as a standard, you don't have another alternative?

Mr. DOLAN. I don't think so.

Senator BRADLEY. Well, let me thank all three of you very much for your testimony.

Now, our next panel is Theresa Dietrich, Program Specialist, New Jersey Division on Aging; Edith Edelson, New Jersey Federation of Senior Citizens; and Philip Rubenstein, Director, Ocean County Office on Aging.

I'd like to welcome all three of you to the Committee and say we look forward to all of your testimony.

And therefore, why don't we begin in order of your alignment. Theresa Dietrich, why don't you begin first.

STATEMENT OF THERESA DIETRICH, PROGRAM DEVELOPMENT SPECIALIST, NEW JERSEY DEPARTMENT OF COMMUNITY AFFAIRS, DIVISION ON AGING

Ms. DIETRICH. Thank you, Senator.

My name is Theresa Dietrich and I represent the New Jersey Department of Community Affairs, Division on Aging and we thank you for this opportunity to present our views on S. 1076, a bill to improve the availability of home health services under the Medicare Program.

And we also commend you for your interest in ensuring high quality home health care for Medicare beneficiaries.

Care in the home, the traditional setting, is still preferred as it has been in the past. People would rather be in familiar surroundings. In many ways, home care is more efficient. Service needs may fluctuate, and the home setting allows for flexibility. Another advantage is that in the home, care can be shared by formal and informal providers, thus reducing the cost. And, of course, home care can either reduce or negate the cost of institutional care.

But the mainstay of home care, the informal support system, often does not exist for the increasing numbers of elderly who live alone or are without families. The proportion of older persons living in a family setting decreases with age. Of all older people in New Jersey, at least 30 percent of those 75 and older live alone. Projections suggest that in 1995, half of the households headed by women 75 plus will be comprised of those living alone or with non-relatives.

And as you, Senator, heard in previous hearings, there are many older persons with serious unmet home care needs. In today's testimony you heard that, as well. And this situation is aggravated by the restrictions under which Medicare reimburses such services. Since the DRG system results in shorter hospital stays, people are frequently discharged still in need of assistance while they recuperate at home, where most receive care from family members or friends. However, this can be a problem for those elderly who either live alone or with a spouse who may be unable to provide adequate care.

New Jerseyans have already testified concerning the tremendous increase in the rate of denials for home care reimbursement by Medicare intermediaries. We applaud your efforts to clarify current eligibility criteria, and to extend the period of time in which daily home health care can be provided. With the passage of this legislation, too, it will also become possible for beneficiaries to receive non-skilled home health care without a prior hospital stay. Equally important is the fact that the bill also addresses the quality issues and provides for the strengthening of the appeal process. New Jersey already requires that home health aides be trained in order to qualify for certification—extending this nationwide should benefit all Medicare enrollees.

These positive changes should correct some of the problems with home health reimbursement for acute care and made it more accessible for our older citizens.

But we cannot forget the health care needs of the chronically ill. This is an urgent problem, not only for older functionally impaired persons, but for their middle-aged or even elderly children as well.

Every year more and more New Jerseyans are living into their eighties and beyond. For some of us that good news is tempered by the fact that increasing age carries with it an increased incidence of chronic illnesses and accompanying functional impairments. The issue of reimbursement for chronic care remains to be addressed. The services needed by the chronically ill often include non-medical, supportive services. A Government Accounting Office study estimated that nearly 1.3 million elderly citizens do not receive adequate help if they need assistance in such activities as getting out

of bed, bathing, preparing meals, and performing other activities of daily living. At the same time that the GAO documented unmet needs, they recommended even stricter interpretation of present HCFA regulations, perhaps because of growing costs for home health care. However, even with recent increases in home care cost, these expenditures represent less than 1 percent of the Medicare budget.

Clearly, a legislative remedy is necessary to help Medicare beneficiaries who need quality health services at home because of their illnesses or impairments. Medicare was designed, of course, to reimburse costs of acute care and is currently unable to provide the non-medical, supportive services that are needed to help people remain in their homes. The time has come to change that.

The need for change is apparent when one studies the results of the 1984 National Health Interview Survey, which found that 32 percent of the non-institutionalized 75 plus population reported difficulty with activities of daily living. If we use this percentage to estimate the needs of New Jersey's population, we see that 119,000 persons 75 plus would be expected to report difficulty with activities of daily living—that is, dressing, bathing, eating, getting out of bed or chair, or toileting. About 13 percent, 15,470, are currently receiving subsidized home care services. Thus, about 100,000 New Jerseyans 75 plus in need of assistance must either rely on their own formal and informal support system, or do without any help at all.

Government reimbursement systems have the effect of encouraging the institutionalization of those who are functionally impaired. Yet, one's home is the location of choice for most elderly people. The advantages of care in the home previously discussed in relation to the acutely ill are identical for those suffering from functional impairment as well. In addition, long-term care services provided in the home have the potential of easing the public burden of institutional care costs.

It is said that public policy is seldom made until a crisis is upon us. But when the issue is care of our chronically ill fellow citizens, we cannot permit that crisis to occur. S. 1076, we feel, is a step in the right direction. Thank you.

Senator BRADLEY. Thank you very much, Ms. Dietrich.

We'll now hear from Edith Edelson.

STATEMENT OF EDITH EDELSON, NEW JERSEY FEDERATION OF SENIOR CITIZENS, INC.

Ms. EDELSON. Thank you very much, Senator Bradley, for your amazing understanding of home—the need for home health care and all its ramifications and for coming to our state and making us aware of it and helping us.

The Statewide Federation of Senior Citizens greatly appreciate your leadership in recognizing and publicizing the kind of health care that is most vital in making it possible for old people to lead an independent life in their own home and community, namely, home-based quality health care. Your bill needs and deserves active widespread support. It gives seniors the opportunity to use our or-

ganizational and individual power to improve the quality and accessibility of home health care.

Demographic studies reveal the rapid aging of New Jersey's population. It is estimated that by the year 2000, one of every seven New Jerseyans, 14.7 percent, will be over 65. And the fastest growing group, those over the age of 85, is expected to double by the year 2000. And looking at 2000, we can't forget the present situation; they are here and their needs have to be tackled.

What must be done to have these services in place when we need them? I'd like you to think about this: When our country was young, we focused our attention on the children. Their primary need was education. Could the young country afford it? Afford it or not, our government, nevertheless, provided for compulsory education. Should the government abandon the people that have grown into old age by withholding the services that are the primary need of the elderly, the question of health care in the home?

Thanks to the wonders of the medical system and technology, people are living longer, much longer; but with this comes chronic illnesses. We can adjust to these while still maintaining our independence—provided certain services are accessible and affordable.

Can the elderly afford the full cost of health care services in the home? Nationally, one out of five people 65 years old or older, and two out of five elderly black people receive at least 90 percent of their income from Social Security. Can they afford to pay for their own health care in the home? Thus, we have to depend on Medicare to help pay for this care.

But we find that the Administration and the Health Care Financing Administration have redefined some of the terms used in federal regulations, as well as in other ways, to reduce the number of people eligible for Medicare reimbursement.

And so we have to turn to Congress, our elected officials, to overcome the indifference of the Executive Branch of the Federal Government and to enact a law for the improvement of home health care services and to make them available to all who need them.

When we talk about Congress, what we're talking about is using the power that we have as voting individuals.

The question was raised, "How do we improve quality insurance?" And the statements made and the provisions deal with paperwork, statistics, things like that, which take us away from the people involved.

The most basic quality insurance factor is ourselves. Think of that.

But here we find what can be called the "Ostrich obsession." If we don't look, home health care will not be our problem. So our people bury their heads in the sand for safety. The reality, however, is that if we're fortunate enough to live long enough, sooner or later we ourselves will be faced by the need for home health care. When such times come, we don't want to be warehoused; we don't want to be an intolerable burden to our children. They will also be old and in need of health services.

And so we dare not procrastinate; we dare not tolerate policies that will deprive us of our right to quality health care in the least restrictive surroundings. There's a Chinese proverb that is relevant and a guide to be followed. It states: "The wise man digs a well

before he is thirsty." We must put home health care services in place now while our health permits us to take action, so that these services will be available to us when we ourselves need them.

Fortunately, Senator Bradley has given us a tool, his bill, that can be the focus of our efforts. In order to be effective advocates for his bill, each of us has to make the following commitments:

One, keep informed about what's going on in Washington regarding home health care and Medicare. There are organizations, nationally and statewide, that will keep us informed; among them the New Jersey Federation of Senior Citizens which, for a nominal sum, will mail its monthly newspaper, Senior Power to your address so you can keep abreast of important issues of the day. I say this seriously; not just in a very narrow sense. There is also the New Jersey Health Care Coalition which you and your organization can join, which focuses on united action in the whole area of health care.

Two, translate your knowledge into action. Be an advocate for the passage of Senator Bradley's bill. Be a pen pal to your members of Congress. Write, telephone, visit them. Spread your knowledge and advocacy efforts to other seniors so they, too, will write, telephone and visit their members of Congress. United action is what guarantees success.

I think I can speak for the senior citizens of our State when I say that we are resolved not to tolerate policies that deprive us of our right to quality health care and independent living.

Thank you, Senator Bradley, for your home health improvement bill and for taking the time to conduct this hearing. Armed with the information that you have given us, we will, I'm sure, carry out our responsibility to advocate on behalf of your bill and our needs.

Senator BRADLEY. Thank you.

Now we'll hear from Mr. Rubenstein.

Welcome.

STATEMENT OF PHILIP RUBENSTEIN, EXECUTIVE DIRECTOR, OCEAN COUNTY OFFICE ON AGING

Mr. RUBENSTEIN. Thank you, Senator.

Unfortunately, part of being the last witness is that everything you wanted to say has already been said.

But anyway, Senator Bradley, the bill S. 1076, what we're talking about, to amend Title XVIII of the Social Security Act to improve the availability of home health services under the Medicare Program generally is a step in the right direction.

The Committee bill attempts to ensure that high quality home health service is available to elderly individuals who need it.

Any bill that restricts HCFA from arbitrarily restricting home care service has got to be good.

Second, the bill mentions the upgrading of home health quality standards and accountability. Again, that is the right direction.

But as mentioned in the S. 1076 Bill, there are still large numbers of elderly with serious unmet home care needs. The present structure is simply not designed to meet the basic home care needs of the elderly.

Presently, the greater majority of our elderly's basic needs are not being met and other sources of support are very limited.

Take the individual where there is no family; very limited funds, and the only income would be their Social Security checks. Where do they turn?

Here in Ocean County we have hundreds and hundreds of our elderly who need help to get out of bed to bathe, to have someone prepare meals and perform other basic daily activities. Home health services under Medicare does not cover this custodial service. Presently, Medicare will only pay for part-time skilled nursing care for a very limited time, as the present regulations state.

The Committee bill under the category of non-skilled care, we understand, would provide for Medicare coverage of up to three weeks of post hospital skilled and non-skilled—this is very important—non-skilled home health care, as long as the costs do not exceed the cost of care in a skilled nursing facility. And that part of the bill is good.

So, in general, Senator, we hope the Congress will accept and approve this legislation. This bill will help the thousands of people throughout the nation that have previously been denied.

But in the long pull ahead, we must look to our vast elderly population who do not meet all the requirements that one must have to qualify for home health services. As you know, Title IIIB of the Older Americans Act cannot financially cope with this problem. We need further assistance of the Congress to help the helpless who need custodial care for long periods of time. Here, Senator, lies our greatest need—coverge for non-skilled home health services—regardless of prior hospital or skilled nursing confinement.

Title IIIB of the Older Americans Act could help, but the Congress of the United States is not looking at it with the emergency status that is factual and actual.

Another emergency problem—and this is a very important thing—is the lack of experienced Registered Nurses, Licensed Practical Nurses, nurses-aides and visiting homemaker-aides. Congress should look to give incentives to broaden the opportunities so we can get people to go into this field; because, again, as I say, in the long pull ahead, if we don't have experienced and proper personnel to take care of our needy, all we do, everything we do is in vain, if we don't have the people to take care of these sick people.

The Ocean County Office on Aging is now funding, in a limited amount, the Alzheimer disease respite program. Here we have a typical example of home respite services to the unfortunate persons that have this illness. More and more of these cases are coming to our attention.

The Visiting Homemaker Service in Ocean County is giving the patient assistance in any way they can; but, most important, giving the family around the patient an opportunity to take care of their normal needs. Again, we are facing a problem that is not covered under Home Health Services under Medicare. This is considered a custodial service. Again, a shortage of personnel to take care of such patients.

We appreciate your outstanding efforts Senator, and your humane understanding of the problems. Your recent bill that you recommended to the Committee, S. 2586, a bill to require services

to establish a respite care demonstration project, I think is one of the most important things that should be taken care of right now.

Here is where the problems lie, respite care and home health care services of custodial people. Senator, we know—I've known you for many, many years, and I've worked with the elderly now for 44 years. I remember when years and years ago we never thought of putting a parent in a nursing home. It was the obligation and the responsibility of the children to take care of the parents.

We're living in a different world today. Everyone has their own responsibilities and everyone has their own needs. We need help. We need help from the Congress of the United States; we need help from our state people. And we've got to help the people who need us most.

And I want to again thank you for giving me the privilege to address you, Senator. Thank you.

Senator BRADLEY. Let me thank the entire panel. And I'd just like to ask a few questions, if I could.

I think that you've made an important point about the fact that Medicare, as it's now structured, does not meet the long-term care needs of the elderly who are chronically ill, and the functionally impaired elderly.

So, the question is, do you think that we should restructure Medicare to do this, or do you think that we need to put a whole new system into place?

Ms. Dietrich.

Ms. DIETRICH. Thank you, Senator.

I think that it could be worked into an additional part of Medicare on restructuring of Medicare. I was hoping that the current debate on this would evolve into something that provided some reimbursement for chronic illness, but, I don't see that coming out now.

But I think another part of Medicare, where perhaps people pay on a sliding scale, might be something that would be feasible.

Senator BRADLEY. Anyone else?

Mr. RUBENSTEIN. Recently we had Miss Wilson, Deputy Administrator of HCFA of Region Two, at the Kimball Medical Center. I recall Jackie's statement very, very well. We can only do so much under the Medicare Program the way it is written. It was never written in the matter of form that will cover all of these.

The world, as I said before, has changed since the Medicare Program was enacted.

In my judgment, we should take the entire Medicare Program, dump it, and start all over again.

Ms. EDELSON. In the process of dumping something, we don't restore what's good in that program, and there's a lot that is good in the program. And it's geared for acute illness, which all of us have from time-to-time.

I think instead of trying to change the character of Medicare, that we establish a third program. We have Medicare for acute illness; we have Medicaid for the poor. We need something for the chronically ill.

Senator BRADLEY. Thank you very much.

Let me ask you, do you think there are other forms of non-institutional care that the federal government should be offering support for?

Ms. EDELSON. We certainly need it in many ways. We have, I think, in the past—I remember situations when it was put completely in the lap of states. They did such a poor job of it that it was turned over to the federal government. I think we need federal government regulations; and they have to keep—the federal government has to keep its hands on these things.

Senator BRADLEY. One of the fears is that as you expand Medicare coverage for new non-institutional forms of care, that you won't be able to control costs; and certainly, a program which is estimated to be small, may become gigantic.

Are there ways that we could target people for these services and keep the costs under control? Are there types of individuals, types of elderly, that could be targeted for these non-institutional forms of care?

Ms. EDELSON. I'm afraid that by doing so, one person will be in, another will be out. And we know in our many programs how many people are out that have the same qualifications as those that are in. I think, basically, our problem is that people must recognize we have to pay for health care, period. We have to pay more for health care and the government has to pay more.

And when I speak of that, the best approach is to have a national health care program that covers everyone. And if we eliminate some of the duplications of costs under our current programs, the Medicare situation, the private policies and a few other things, it would free quite a bit of money for this kind of program, a preventive program.

Senator BRADLEY. I'd like to ask Ms. Dietrich if she has any comment about that. And in addition, what are some methods that we now have available to measure functional disabilities?

The idea is, if you have a limited amount of money, if you could get the money to the people who need it the most, it will better the chances of dealing with the biggest problem, and you have, also, a program that is within the cost limits. Whereas, if you simply say it's the universe, it's less likely that those who need it will get the care.

Ms. DIETRICH. It's a very complex issue, and I think perhaps the fact that there are already centers that monitor things like activity of daily living deficiencies, that perhaps a program could be—would limit—the entre could be limited according to moderate or severe deficiencies and ability to carry on activities of daily living.

There seems to be a certain amount of data in literature on which these things are measured. So perhaps the skill of measuring these statistics—I don't know; I don't know anything about surveys—but perhaps there is a little bit of expertise already in the system for counting these kinds of things.

Senator BRADLEY. I think you make a very interesting suggestion; because in the four-state respite program that Mr. Rubenstein pointed to, the criteria is that someone needs help in at least three of the five activities of daily living. That was, indeed, the way that it was structured in his respite program, to get the assistance to

people who need it most, people who would be impaired in bathing or eating or whatever.

Ms. DIETRICH. Or several of those.

Senator BRADLEY. Three of the five.

Ms. DIETRICH. Right.

Mr. RUBENSTEIN. That's right.

Senator BRADLEY. Would you agree with that, Mr. Rubenstein, that that's one way you could do this?

Mr. RUBENSTEIN. That is the essence. Specifically, your respite program that you introduce, I think that this is one of the greatest steps so far that we've had in the last ten years. And I certainly believe that once you start this demonstration project, it will pass on its own. This will be the first step of how far we can go.

I'd like to bring out one more point. As you probably know, we all know the catastrophic health care program will probably be passed very, very shortly. We're going to watch this very carefully, for the simple reason that this might solve some of the problems, but it's definitely not solving the custodial problem. And that's where these troubles lie.

In our audience today we have the coordinator and the head of the Ocean County Health Department, Mr. Kaufman. He's sitting there right now. And I don't think there's any other man in this county who encounters the greatest problems of what's going on between our sick people. If he had an opportunity to tell you what's going on, he would probably substantiate everything that I said.

So, two things we have to watch, number one, catastrophic health care programs; number two, your respite demonstration program; and if that all falls through, it's going to cost money, but I think——

Senator BRADLEY. OK. One last question I'd like to ask Ms. Edelson.

In your opinion—and it's my opinion—Medicare traditionally has been biased toward institutional care. The question is, why do you think that is?

Ms. EDELSON. Well, one reason is—it's hard to think about that. One reason might have been that in 1965, when it was put into place, chronic illness hadn't taken hold, and people's knowledge about chronic illness hadn't taken hold. And so, acute illness was a great need of the day.

And this is a very superficial and partial answer to you, but that would be one of the reasons.

Senator BRADLEY. Let me thank all three of you very much for your testimony and for joining us today.

I would like to thank all of the panel members for taking the time to come today and offer their thoughts. I've often said that I'm only as good a senator as I have people who are interested in giving me information. And I think that this effort to improve home health care for the elderly flows directly from the information that we've been able to derive from these hearings. And that information is taken back to Washington, and we put it into bill form, and I think in some of these areas we are about to achieve a win that will be the win, I think, for senior citizens.

But I do want to point out that this is not a sure thing at this stage. It's going to be an uphill battle to get this through Congress this year.

We discussed increasing the number of days of home care coverage from two weeks to 45 days. That is embodied in the catastrophic health bill. We talked about changing the definition of "homebound." That is also embodied in the catastrophic coverage bill.

And I might say that both of those the President has threatened to veto. And on improving the quality of health care, that will probably be in the reconciliation bill, which is also something that the President has threatened to veto. Not necessarily because of those provisions, but because of the overall bill.

So, I would urge all of you—I think it was Ms. Edelson's advocacy—to write to Senator Lloyd Bentsen who's the Chairman of the Senate Finance Committee; and that's the Senate Finance Committee, Washington, DC 20510. And when you have your pen and paper out, also write, please, to the President and tell him how important this issue is to you and that you want the catastrophic bill and you want, also, expanded home care coverage.

I'll continue to push for improvements in the Medicare Program, both as it addresses acute care problems and as it addresses the much larger problem, which is care for the long-term chronically ill elderly. I think it is an improvement that as a result of increasing daily home care coverage from 2 weeks to 45 days, we will be able to give 10,000 more New Jerseyans home care when they return from hospitals.

There's still a long way to go, though. We've done a number of things to help. Two years ago we sponsored a four-state demonstration to assist elderly in need of long-term services to remain in their homes. I hope that's going to come to fruition. We have the respite care bill, which we just talked about, that will actually be implemented this winter. And I will continue to work on legislation to expand Medicare to cover adult day care for the functionally impaired to meet some of the long-term care problems of the elderly.

And the next step I think should be Medicare coverage for home care to again meet some of the long-term care needs of the elderly.

This boils down, really, to what we think we owe, as a society, to the elderly. Frequently, in these meetings it comes down to what we think we owe to those in the twilight of life. There's a more basic choice. It's what we think we owe to another human being. And I think that everyone who participated in this hearing agrees that we owe an elderly person a chance for adequate health care, in this case adequate health care in a home setting.

So I want to thank all of you for testifying. You've been enormously helpful. And I want to thank, also, the board for allowing us to hold this hearing in this setting for all of you who attended and for all of the witnesses.

Thank you, and the hearing is adjourned.

APPENDIX

MATERIAL RELATED TO HEARING

Item 1

OCEAN COUNTY HEALTH DEPARTMENT
C.N. 2191
Toms River, N.J. 08754
201-341-9700

CHARLES KAUFFMAN
PUBLIC HEALTH COORDINATOR

TESTIMONY REGARDING MEDICARE HOME HEALTH SERVICES IMPROVEMENT ACT OF 1987

By

Dale Wilson, R.N., M.S.N.
Assistant Director, Public Health Nursing Services

Good morning everyone. I am here as a representative of the concerned public health nurses of the Ocean County Health Department. We are the individuals who are out in the community fighting to provide home care under the existing Medicare regulations. Let me tell you we are losing the battle but there is hope with this proposed legislation.

We are therefore in support of all aspects of the bill but I would like to concentrate on the potential benefits there are to the delivery of public health nursing care.

This proposed legislation is based on testimony which presented numerous examples of inconsistent denials for service based on ambiguous eligibility criteria of "intermittent care". The problems in home health care are overwhelming but if this legislation passes, at least we will be assured that the post acute home care of the elderly,originally intended by Congress will be preserved.

We are all aware that the original intent of Medicare was to focus on medical convalescence, not supportive nursing care. Limitations were developed to assure federal payments of medical care based in the home.

Nurses began providing home health care before Medicare came into existence. We are prepared professionally to assess a patient holistically within their family unit. To identify a family's strength as well as their weaknesses.

The threat of denials are a constant frustration. Public Health Nurses believe that Medicare is attempting to dictate their nursing practice. We are aware of our responsibility in deciding whether patients can utilize care allowed by Medicare. If the care is not

covered, we are expected to deny coverage under Medicare and either place the patients on a self-pay regimen or refer them to appropriate care elsewhere. This process has become more difficult with the increasing denials for care we assess as meeting the Medicare criteria.

The choices are less clear for those patients who have excessive home care needs. Nursing home placement is one option for these patients. Public Health Nurses often opt to keep the patients on home care and provide the additional nonreimbursable care. As you are aware these services are not truly "free".

The services which are not reimbursed by Medicare include:

- extensive family health histories
- home safety assessments
- the adaptation of care to the home setting
- coordination of medical appointments
- coordination of community resources for the family
- counselling, and home health maintenance

Bill 1076's clarification of the Medicare home care benefit would assist in the provision of all services required as originally intended.

In relation to the home health quality provisions within the bill, we agree that key components of publicly funded programs - quality and outcome - are missing from the Medicare home health services program.

Bill 1076 proposes a choice between current health policy which provides that a specific process be followed and a different type of policy that stresses the achievement of specific outcomes. Under an outcome system, reimbursable care would be determined by what was needed to achieve the desired health status. In some cases it might be professional services, in others only home health aide service might be required. An outcome system will complement Bill 1076's proposal for reimbursable non-skilled care.

In conclusion we are encouraged by the fact that some of our country's leaders have recognized the need to expand home health services to meet the long term needs of the elderly and disabled. Bill 1G76 is a beginning. But we all need to remember the desires of the elderly remain the same: a long, healthy life, independence and the opportunity to remain in their own community. If they are to achieve all this, more than acute or convalescent medical care services will be required. The challenge is for the development of a policy that meets the needs of this population in a cost-effective manner acceptable to all of society.

Item 2

New Jersey Council of Senior Citizens
STATE HEADQUARTERS
16 Commerce Drive, Hasbrouck Heights, N. J. 07016
Telephone: (201) 272-4800

PRESIDENT
MARY E. JOHNSON
JERSEY CITY

EXECUTIVE SECRETARY
ANTHONY FERNANDEZ

Senator Bill Bradley Forum August 3, 1987 Lakewood, N.J.

The needs of our growing elderly population have been well documented, and the efforts by our legislators, such as Bill Bradley, are being made to address some of these needs. The legislation currently pending will help some of our seniors, but even if all of the proposed bills become law, the real medical needs of our nation will still be with us.

Statistics show that:
*More than 35,000,000 Americans have no health coverage at all;
*Our infant mortality rate is among the highest of the industrial nations of the world;
*Medical costs in the United States are now approaching 14% of our gross national income, almost twice that of countries with national health programs;
*Malpractice suits are forcing countless doctors to give up their specialty and/or to leave the practice of medicine;
*Persons within health insurance programs find that their coverage is inadequate and that their additional out of pocket costs are so exorbitant that it is beyond their means;
*Life expectancy in the United States is now lagging behind other countries.

The United States is one of only two countries in the industrial world with no national health program. It is long past due for this nation to look towards establishing a national health program in these United States. Our costly and fragmented current health programs are too inefficient and expensive to administer. Our health insurance policy premiums are too high compared to their payout rates. And, big business can no longer afford the costly fringe benefits it has offered in the past.

Our thanks to Congressman Claude Pepper for sponsoring an amendment to HR 2470 that calls for a Bipartisan Commission to study the feasibility of a national health program. And our thanks to Senator Bill Bradley who is sponsoring the same amendment in the Senate. Such a study is the first step in addressing the real health needs of this nation.

Respectfully submitted,
David Keiserman
David Keiserman,
Legislative Representative

Item 3

NEW JERSEY OCCUPATIONAL THERAPY ASSOCIATION
P.O. BOX 773, UNION, NEW JERSEY 07083
(201) 744-0894

August 3, 1987

Senator Bill Bradley
Public Hearing on S 1076
Levovitz Apartments
500 Clifton Avenue
Lakewood, New Jersey

Dear Senator Bradley,

As President of the New Jersey Occupational Therapy Association and as an occupational therapist who has worked in Home Health for over 23 years, I opper my gratitude and support for your bill, S 1076, and the improvement included within it.

Working for a Home Health agency, formed at the inception of Medicare to meet the needs of its recipients, I have observed home health rehabilitation and intervention at its best, as in the early days, and at its worst, as it often is today. At the outset, many Home Care patients reached high levels of functional independence when treated in their homes. After the home care program was completed, patients rarely required daily outside assistance in order to function. Patients were able to receive appropriate interventions for the time they were medically necessary. Eventually patients resumed their previous life styles. Occasionally, they required adaptations in technique, environment and/or equipment to attain the highest degree of functional independence possible within the limits of their various disabilities. Today under current Medicare restrictions placed on rehabilitation services and the fear of denials by agencies, the patient is fortunate if he or she begins to perform the most simple movement or task before service is terminated. There is no longer enough reimbursed visit time to teach patients to adapt, adjust or relearn how to care for themselves and to function independently once again at home.

Redefining "intermittant" and "homebound" will assure that many more persons will receive the necessary care to improve their medical conditions to a higher level than has been possible in the past 18 months. Including Occupational Therapy as a skilled, "qualifying" service will also assure that patients will receive the appropriate therapy when required to assist them to regain their highest possible level of functional capabili ty and independence.

Some of the most frequent disabilities addressed in Home

NEW JERSEY OCCUPATIONAL THERAPY ASSOCIATION

P.O. BOX 773, UNION, NEW JERSEY 07083

(201) 744-0694

Health care are persons who suffer from strokes, exacerbations of Rheumatoid Arthristis, Parkinson's Disease, Multiple Sclerosis or ALS (amyotrophic lateral sclerosis). If these persons can have occupational therapy included in their prescriptions when it is medically appropriate and necessary, without having to qualify for another service which may be unnecessary in order to implement occupational therapy, they will learn techniques which will assist them in using their bodies more effectively. They will increase their capability for caring for themselves safely and with dignity.

Acknowledging that a medical insurance program may not be able to provide everything for everybody, there is still a need for clarification and change to allow the providers to give the most appropriate service for the amount of time alloted to effect the greatest change possible. Under your proposed improvements, this will be possible. It would seem sensible and more cost effective to be able to provide treatment to subscribers which would enable them to attain as high a level of health and function as is medically possible so they may remain in their own homes. Long term care facilities should be the last resort for health care NOT the immediate alternative when persons are discharged from the acute care setting. Long term care should be reserved for those persons who can no longer be helped by home health medical services provided in their own homes.

Thank you for your authorship and promotion of this necessary and vital and humane bill. It will provide a higher level of care to all the elderly and disable persons covered by Medicare throughout the country.

Sincerely,

Theodosia T. Kelsey, FAOTA, OTR
President, New Jersey Occupational Therapy Association

Item 4

The Hon. Bill Bradley
Senator
State of New Jersey

My name is Stella Lass. I reside at 118 15th Avenue, Belmar, N.J. I also reside in the wintertime in a Senior Citizens Condo minium Commnity of 15,000 residents, in Deerfield Beach, Florida. This gives me an opportunity to see at close range the problems of the old in two states which are noted for the large number of retirees and retirement communities.

I want to speak particularly to the subject of long term, unlimited in time, as long as the patient needs, homecare. Not the homecare which depends on a referral by a physician after a hospital stay and which is limited, under Medicare, to 21 days.

With your permission, may I describe to you the North Broward Homebound Program of Pompano Beach, Florida, which a group of us started in April, 1985. We were able to pursuade the administrator and the Board of Directors of a County Hospital, the North Broward Medical Center, which is located near our community, to help us with a concept of care for the homebound who are not eligible for Medicaid. The concept is a threefold sharing of the cost of homecare between:

I. Public Funding (Federal, State, County, Municipal)
II. Patients paying what they can afford
III. Private Contributions (United, Jewish Federation, Foundations)

The hospital staff helped us apply to the State Health and Rehabilitative Services Department. Our project was designated a demonstration project and funded for 21 months. This funding is to be terminated this coming December.

The hospital provides us with a fully furnished office, 24-hour telephone service, the director's salary and the services of their attorney. Quality of service is monitored by a State team and volunteers. Service is given to patients within a radius of four miles of the hospital. Aside of the director, the permanent staff includes a nurse, a social worker and a bookkeeper-clerk.

The procedure for providing service starts with a call from the patient or some one close to the patient. A visit by the nurse and social worker to assess the needs and the ability to pay by the patient. The North Broward Homebound Program, a non-profit organization with its independent Board of Trustees, oversees the quality of full services from agencies who bid for the priviledge of providing service.

We began full service in May 1986. In the brief time of a little over a year, we have served over 700 patients. We have found that patients can pay approximately 40 to 50% of the cost. The rest comes from the state grant, the hospital contribution and a unique way of collecting voluntary contributions. Our condo community established a Self-Help Fund, with a $12 annual contribution per unit. This help goes only to patients of the condo community. Todate we have collected $26,000. $12,500 have already been contributed by the Fund.

We have recently had the great priviledge of being accepted by the United Way as a full member agency. Another indication of approval of our program has been notice given us that the Broward County Commission will include us in their budget. Whether this funding will allow us to pursue our goals, remains to be seen.

I do hope you will find this concept of cost sharing interesting enough to explore it further with the prospect of including Federal funds as part of this cost sharing so as to insure long term, limited only by the patient's need, homebound care.

Respectfully

Stella Lass, Acting Pres.
North Broward Homebound Program

Item 5

Testimony in Support of the Medicare Home Health Improvement Act of 1987

Sharon Breidt, RN
Staff Nurse, Extended Intake Coordinator
Middlesex County Visiting Nurses Association
Discharge Planning Nurse Coordinators of New Jersey

August 3, 1987

Good Morning Senator Bradley, Colleagues, and Friends:

My name is Sharon Breidt and I am a public Health nurse employed by Middlesex County Visiting Nurses Association. I am speaking to you on behalf of the Discharge Planning Nurse Coordinators of New Jersey. The fact that I function both as a provider of direct home nursing care and discharge planning puts me in the unique position of understanding both hospitals and home health agency problems in serving clients well under such limited reimbursements.

I am very concerned about the changing environment of home care reimbursement. I feel this change has two main components. First, with the advent of DRG's and prospective payment, we have seen evolve a client population which is much more complex. Our clients are are being discharged home from the hospital while still in the acute phase of their illness yet home health agencies are expected to serve these clients in shorter time frames while providing less services than ever before. The second component is the fact that since 1984, Prudential, the fiscal intermediary for Medicare, has more stringently interpreted and reinterpreted the reimbursement guidelines.

The Medicare Home Health Improvement Act is pivotal to assist our elderly Americans to recieve the help they deserve and so desperatley need. There are two specific aspects of this bill I would like to focus on. First I would like to speak about Section 4- the requirement that an individual be confined to home. In recent years HCFA has been leaning more and more towards interpreting homebound as meaning bedbound. Many of our clients live alone or are alone during the day. They are in desperate need of teaching to relearn how to perform their activities of daily living, safely, within the new constraints of disability of their recent illness. A few examples of these disabilities would be shortness of breath with minimal exertion, weakness, and pain. These disabilities would make a person homebound yet not neccessarily bedbound. The public health nurse is

able to assess that client's changed status and coordinate the neccessary health disciplines needed to meet that client's needs. In most cases this intervention will keep the client home and prevent frequent rehospitalizations.

Another aspect of this bill I would like to focus on is Section 5- regarding occupational therapy. Occupational therapy can not be so narrowly interpreted that it is used only when there is a functional loss of movement in an upper extremity. Occupational therapy should be more broadly defined to include learning compensatory techniques. A client was referred to us after a second hip fracture and pinning. Once a hip is fractured there are certain positions one must avoid to prevent reinjury. This client recieved occupational therapy services which enabled her to recieve teaching regarding hip precautions, which will prevent further injury. Occupational therapy services were initially denied however were reversed on appeal. The time spent on reversing the appeal due to the narrow interpretation should not have been neccessary.

Teaching done in hospitals is limited. There is a shortage of staff and most clients are overwhelmed during that most acute phase of their illness. Teaching at home is much more effective. The client is in her own environment. This is extremely important because the client is more comfortable and teaching can be made more specific. For example, a nurse teaching a client about his or her proper diet can sit with that client in the client's kitchen and modify the teaching to include the foods the client is most likely to eat. Another example is the occupational therapist who can teach hip precautions to the client specific to the layout of the clients home.

In conclusion, I would like to say that I am very excited to be given the opprotunity to voice my opinions on this very vital piece of legislation. With provisions to ascertain that clients recieve the home health care they are entitled to, I feel we will see much less hospital readmissions. Thank-You Senator Bradley for your insight into the needs of our seniors from hospital to home, and for introducing this piece of legislation to help meet those complex needs.

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